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SOME MODERN DEVELOPMENTS IN OPHTHALMOLOGY AND THE RELATIONSHIP OF THE SPECIALTY TO GENERAL CLINICAL MEDICINE.*

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It is a mere truism to say that ophthalmology should be one of the most scientific departments of medicine. The ultimate aim of science is the prediction of the future; and this, by the correct interpretation of phenomena over so wide a series of instances as to lead to the discovery of the laws which govern their occurrence. And it is just in so far as we can approximate to this ideal that we can speak of our work as scientific. I have for long felt very strongly that the first essential to any scientific work is the making of a record of all observations. Nothing so much prevents slipshod work. And, apart from its convenience to oneself and advantage to the patient, as a mental discipline in the scientific method to the observer it is of untold value. Now, the more accurate our observations the more accurate our records, and, a priori, our deductions therefrom. It is to some of the means of precision at our disposal that I wish in the first place to refer. In no other branch of medicine can the question be more pertinently asked, why guess when you can know?

The first improved appliance to which I wish to draw your attention is the electric ophthalmoscope. Of course, every general practitioner should be able to use the indirect method with facility. All that it requires is the possession of a concave mirror and a lens. It is almost as essential to his clinical equipment as the ability to use the laryngoscopic mirror or the aural speculum. This instrument is a great improvement on the old reflecting one. With five minutes' practice the novice can see the fundus clearly and easily by the direct method. It can be lighted from the main current or from a dry cell, and, with it, there is no excuse for ever missing any abnormality of the fundus and media. A dilated pupil, except for the minute examination of the macular region, or a darkened room, is unnecessary.

Another appliance of precision is the Schiotz tonometer. This enables one to state the tension of the eye in terms of millimetres of mercury. Except for the time being to note that the tension is plus or minus, it is now customary to speak of the tension of the eye as so many millimetres of mercury. The limits of the normal are 12 and 27. Apart from the fact that the finger is the least accurate of all methods of detecting a rise of tension, it is as a means of

recording the tension at any given time that this innovation is of such value. I may say that it has stood the test of several years' experience, and its value and reliability, within limits, are established in the minds of most scientific workers. Its use is at least as much called for as that of the clinical thermometer. What should we think of the writer, who, in describing the course of an illness, noted that the temperature was "high" or "rather warm"? Similarly, in studying the course of a case of glaucoma, it is of the utmost value to learn that the tension has varied from 45 to 25 under treatment by eserine, but rose perhaps in a few days to 35. After operation it becomes 8, and a year later is, we will say, 14 mm. on every occasion of examination. What a world of information—definite information—these figures give us, and of what great value for future reference, instead of the vague generalities of "plus one" and so on. I do not wish to over-emphasize the importance of tension as a symptom in glaucoma, but in this connexion it is raised tension which I am discussing, and the modern method of recording it.

I will not dwell further on the many instruments of precision which are provided for those who will use them, making for greater accuracy of observation, but will pass on to the consideration of methods.

Of new procedures probably the most revolutionary are those designed for the operative treatment of glaucoma. I refer chiefly to trephining for glaucoma, with which the name of Elliot will ever be associated. Although this is less brilliant and more tedious and difficult an operation than iridectomy, when once the technique has been mastered, it is one which is infinitely safer for the patient in the acute forms, and more permanent in its results in the chronic.

In the matter of early diagnosis of glaucoma, the work of Bjerrum has placed within our hands a delicate test whereby minute gaps in the fields may be detected much earlier than by ordinary perimetric tests. And the various scotometers on the market facilitate such examinations.

In the treatment of trachoma, that bogie of the practitioner and bugbear of the specialist, a most notable advance has been made on the lines laid down by Heisrath. When once trachoma has reached the stage of cicatrization and contraction, with corneal involvement, I will venture to say that no measure is at once so quick, so certain, or so permanent in cure as that of excision of the tarsal cartilage, with, usually, its overlying conjunctiva. One would expect that this would result in a turning in of the eye-lashes. On the contrary, it is one of the most successful means of treating entropion and trichiasis. I cannot help dwelling somewhat on this theme, because I am sure that if the general practitioner was convinced that the specialist had a

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radical cure for this fell disease, which was both speedy and certain, he would take means to have it made available to all his so afflicted patients. Cases have in the past been sent to oculists, and, after months of treatment, have returned to the country improved a good deal, but have become the victims of distressing recurrences. It must be remembered that the operation of excision only anticipates the natural course of the disease, which leads inevitably to loss of conjunctiva by contraction, during which time the cornea is perhaps sacrificed by ulceration or pannus.

While on the subject of trachoma, may I remind you that what is popularly known as blight is not to be confused with trachoma (granular lids). "Blight" is an acute muco-purulent conjunctivitis occurring mainly in the hot weather, characterized by swelling of the lids and profuse discharge; it is of short duration and is readily amenable to treatment. Trachoma, on the other hand, is a chronic inflammation of the mucous membrane of the eyelids, extending over a period of months and years, characterized in the early stages by discharge (flies often conveying it), later by thickening and deformity of the lids, and often by secondary opacity of the transparent portions of the eye, resulting in extreme disability, and frequently in blindness.

In cataract again, it is no longer necessary to wait till the patient is totally blind. The Indian operators have shown us that very free flushing of the anterior chamber may be safely done, whereby residual cortex can be removed. This, with subsequent needling, if necessary, brings an earlier operation within the reach of the cataractous blind.

But perhaps the most notable and fundamental advance made in the specialty is the ever-increasing realization that the eye cannot be viewed as a detached organ; and this brings me to the second heading of my essay. There is hardly a disease of the eye which is not the result of some infection, dyscrasia, diathesis or degeneration. The exceptions are perhaps developmental defects and neoplasms, though not always can even these be dissociated from concurrent or antecedent lesions elsewhere.

A diathesis may be defined as a permanent condition of the body, hereditary or acquired, which renders it liable to certain special diseases or affections, and is, in fact, a condition of the soil. An infection is the soil on which a germ has been implanted and has flourished. A short clinical experience serves to prove that micro-organisms behave differently when they are cultivated on different soils. The most familiar and striking examples are to be seen in the ravages wrought by the tubercle bacillus in those who are "scrofulous," and by the gonococcus in those who have "arthritic" tendencies. Some affirm, and it is possible that future investigation may prove, that in its beginning every diathesis is an infection; but our present clinical knowledge does not permit the final acceptance of that view. The success that has attended serum and vaccine therapy is due to the proper recognition of the soil as well as of the germ; and we know now that microbial infection can only be successfully overcome by immunizing the blood.

The oculist is thus always brought back to the individual and his special proclivities to disease. He must treat his patient as well as the disease, recognizing that he had a certain diathesis—a family history, hereditary proclivities and certain personal peculiarities. The beginning and end of his practice is treatment; and by treatment I do not mean simply the administration of drugs, and still less the mere topical use of them, but the making use of every agency or circumstance which can help to bring about the patient's recovery. Under no pretext whatever ought the eye specialist to dissociate himself from the general treatment of the patient, because success in combating the ocular inflammation depends entirely on the supervision of every detail in the regimen prescribed. Of course, this will be carried on, whenever possible, in conjunction with the patient's medical attendant, from whom much of value concerning the patient's constitution may be learned.

Maitland Ramsay, whose work on "Diathesis and Ocular Diseases" I would commend to the perusal of every practitioner, and of which I take this opportunity of acknowledgement, recognizes three main types of diathesis: (1) the neurotic, (2) the scrofulous, and (3) the arthritic, with two subdivisions of the latter, the gouty and the rheumatic.

Time will only permit me to touch on this interesting subject, but I will try to give an instance of each. The neurotic patient is usually spare, restless and active. He feels pain very acutely. A small trouble to him may assume large proportions. In such patients a very small degree of ametropia or of muscle imbalance may cause headache, giddiness, sleeplessness and may other nervous symptoms.

Obviously, the correction of refractive error is first indicated in such cases. If this does not give relief, the possible co-existence of functional disorder of the liver should not be overlooked. Lithiasis and oxaluria are common accompaniments of eye-strain. The examination of the urine may give valuable therapeutic suggestions. Free elimination of waste products is facilitated by a dose of phosphate or sulphate of sodium, with potash or lithia every morning. Lauder Brunton's mixture of salicylate of sodium with bromide of potassium often benefits these cases: the former to "clear out waste products" and the latter "to quiet the nervous system."

Other cases require change of air and scene, massage or mental influences. In this connexion I may emphasize the distinction between hysteria, in which there is strength with diminished sensibility, and neurasthenia, where there is weakness with increased sensitiveness. For the former the treatment is suggestion, for the latter rest.

The scrofulous diathesis. We all know the type. A child, probably under ten, pale and flabby, prone to diarrhoea and catarrhal affections. The most typical eye conditions is phlyctenular conjunctivitis or keratitis. The most obtrusive symptoms are lachrymation, spasm of the lids and avoidance of light. On the last symptom the old plan of painting the forehead with liniment of iodine sometimes has a magical effect. But it is necessary to bear in mind

that the essence of the ailment is in the mal-assimilation of food, and that very many cases arise as a result of improper dieting. The first thing to do then is to see that the child has regular food, and no "sweets" between times; sugar, potatoes and pastry should be excluded, and plenty of milk given, and, later, soups, eggs, fish and fowl. In addition, the free elimination of toxins that have accumulated as a result of mal-assimilation must be promoted. The kidneys, bowels and skin should be stimulated to execute their functions. Castor oil or grey powder and rhubarb if the tongue be foul, and hot baths nightly. Later, iron, phosphates and cod-liver oil have their place. On local treatment in this place I will not dwell. Where these measures fail, probably tubercular therapy is indicated. The possible co-existence of adenoids too must be remembered.

The arthritic diathesis. Rheumatism proper, it would seem, is due to a diplococcal infection; but gout is generally regarded as a toxæmia due to mal-assimilation. The subjects of this diathesis are often big, florid and "good doers" generally. A gouty conjunctivitis is characterized by a marked hyperæmia and much discomfort, unaccompanied by catarrhal secretion. It is cured by dietetic and other treatment of the gout, and not by zinc or cocaine drops, which will make it worse.

Other eye affections which call for drastic general treatment of the patient are scleritis and episcleritis, inflammations of the uveal tract, such as iritis, many inflammations of the retina and optic nerve, toxic amblyopias, and last, but not least, glaucoma. These cases will be helped by a purin-free diet, alkalis and calomel. But I have said enough to show the importance of never losing sight of the underlying diathesis of the patient.

Clinical pathology, however, is daily putting still other weapons in our hands. Precision of diagnosis is more often possible as we realize the greater frequency of a definite infection. The Wassermann reaction enables us to mark down syphilis as the infecting agent in a very large number of cases. And again we are realizing every day the larger part that tubercular infection takes in ocular disease. According to Stephenson, 20 per cent., and to Harrison Butler 30 per cent., of cases of interstitial keratitis are due to tubercle and not to syphilis. I have had cases recently of this disease going from bad to worse, which cleared up in six weeks under tuberculin injections. In addition to the phlyctenular conjunctivitis mentioned before, and which is sometimes due to tuberculo-toxæmia, deep scleritis is nearly always tubercular; also many forms of discrete choroiditis. In these cases tuberculin therapy is strongly indicated. Recurrent stytes and severe blepharitis are often cured by staphylococcus vaccines, being only local evidences of a generalized infection: the local incidence being induced by local congestion, the result of a refractive error.

In every case of iritis or deep uveitis, not due to direct injury or infection, one should seek the underlying cause. Gonorrhœa, syphilis and autotoxæmia, using the latter term in its widest sense, are the most common causes, tubercle and diabetes rarer ones.

A very large class of cases of iritis, chronic cyclitis and irido-cyclitis, with vitreous opacities and secondary cataract, is due to septic absorption from the teeth or intestine. I think these cases of pyorrhœa alveolaris are generally associated with intestinal sepsis; that, in its turn, being probably induced by the state of the mouth. Removal of the teeth, asepsis of the mouth and treatment directed to the bowel are far more important than the instillation of atropine, unless the iris is definitely involved in the inflammation.

Time will not permit me to do much more than mention the close association between the eye specialist and the neurologist. The accurate observations of the former will prove of incalculable value in the diagnosis of nervous lesions. The pupil reactions, for instance, and paralyses of the external ocular muscles, in tabes, in disseminated sclerosis, in general paralysis of the insane, in syphilis of the nervous system and in tumour. The visual fields may often clinch the diagnosis of a transient cerebral vascular crisis, and an alteration in the colour fields furnish valuable information as to cerebral disease.

A central colour scotoma may be the means of diagnosing not only tobacco amblyopia, but also diabetes or multiple sclerosis. And how often is chronic Bright's disease first discovered by means of the ophthalmoscope?

But, after all, it is to the pathologist that we eye surgeons owe the greatest debt. The labours of Collins, Parsons, Coats and others have done, and are doing much, to put our work on a more scientific basis. Without a true conception of pathology, what are we but mountebanks? I will cite but one instance of the illuminating value of pathological enquiry. Arterio-sclerosis is a condition of the greatest interest to the clinician. The oculist is in the unique position of being able to see the changes occurring in the retinal arteries; and these changes are usually but a reflex and a part of a general degenerative tendency throughout the whole arterial system. Changes in the retinal vessels of this character are of course part and parcel of the picture in albuminuric retinitis, but, what may not be realized by all, is that they occur quite apart from it, and may be the earliest or at any rate the most arresting signs of impending Bright's disease, and of that arterial state which is the precursor of cerebral thrombosis and hæmorrhage. Some of these changes are hypertrophy of the vessel walls, shown by the increased width of the glistening reflex, tortuosity, a white line of hyaline degeneration running along them, irregularity of calibre, banking of veins where crossed by an artery, new tufts of fine vessels near the disc, a corkscrew appearance of small vessels, and, later, hæmorrhages, œdema, thrombosis and other gross changes.

It will be remembered that the arteries consist of a fibrous coat, a layer of muscle, the elastic lamina of Henle and endothelium. In arterio-sclerosis we get great proliferation of cells between the layer of Henle and the endothelium, and, in the retina, proliferation even of the endothelial cells themselves. This gives rise to eccentricity, narrowing of lumen

and irregularity of calibre of the vessels. There is also a general thickening of the fibrous coat, peri-vasculitis and hyaline deposit, causing the "white line" appearance. The endothelial thickening of the fibrous coat is a response to the high blood pressure. A vicious circle is thus produced. Hypertension and toxæmia causing sclerosis: sclerosis and narrowing of vessels accentuating the high blood pressure. One must realize that, while typical albuminuric retinitis is a comparatively rare, and always a late, occurrence, small hæmorrhages and the other changes I have mentioned may constantly be found both preceding, and as a very early sign of, kidney disease. No case of cardio-vascular disease has been thoroughly investigated unless the eye fundus has been repeatedly examined. The ophthalmoscope will often afford valuable information in these cases. And, as de Schweinitz has pointed out, they represent an importance from the diagnostic standpoint equal to, if not greater than, that furnished by a study of the pulse and cardiograph. They represent phenomena to be studied in living tissue at a place where what is actually going on in the living blood vessels can be observed, as it can be observed nowhere else in the human body, or at the least not so accurately.

My object has been to call attention in a desultory way to the close inter-relation between ophthalmology and general clinical medicine. And while, as specialists, we hope to be of increasing service to the clinician, we must aim at a true perspective. We must approach the problem presented by every patient as we should each problem of life itself, and endeavour not to view it only through the refracting medium of our specialty, but to "see it steadily and see it whole."

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OMENTO-PARIETAL ADHESIONS ASSOCIATED WITH INTESTINAL STASIS.*

By **L. M. McKillop, M.S., M.B. (Syd.)**,
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The subject upon which I intend to address you this evening is "Notes on three cases of omento-parietal adhesions associated with intestinal stasis."

The following three cases, all of which occurred in my practice within a space of five weeks or so, and, strangely too, all in males, are sufficiently instructive to merit a few notes, if only to emphasize the variety of symptoms and the difficulty of diagnosis which are experienced in such conditions.

Case I.—J.J., aged 33 years, engine-driver, consulted me on February 22, 1914, for vague abdominal pains and constipation and diarrhœa alternating every three or four weeks. He gave the following history: In February of last year, whilst at work, he was suddenly seized with severe pain in the right side, vomiting, tenderness and rise of temperature. This attack was correctly diagnosed as appendicitis by his medical attendant, who treated the case on non-surgical lines. A few days later,

however, his temperature, which had sunk to normal, rose again, his tongue became foul and headache set in. In spite of advice, he got into the train and travelled to Rockhampton. Here he was treated for enteric fever, complicating appendicitis. On recovery from the fever his appendix was successfully removed, and he shortly afterwards returned to work. Shortly after, however, he found that his bowels were becoming more constipated, and still later he began to have occasional attacks of thin, watery diarrhœa, and a constant sense of discomfort in the abdomen, with occasional attacks of cramping pains around the umbilicus. He lost weight steadily, became pasty and sallow looking, lost energy and strength and suffered from repeated gaseous eructations until finally he was compelled to abandon his work. His medical attendant preferred to offer no definite opinion regarding this new condition of affairs, but advised an exploratory operation. In this plight he consulted me. On examination, his temperature was 98° F. and pulse 86; his tongue was rather dry and furred, breath distinctly fœtid, and he complained of a dull headache, and looked decidedly "below par." He was anæmic, his muscles wasted, the abdomen was tumid and tympanitic, and there was distinct tenderness to palpation over the umbilical region. Even after clearing out his bowels on the following day with oil, followed by enemata of turpentine and asafoetida no mass could be felt anywhere in the abdomen, nor were the kidneys out of their correct position. The urine was offensive, probably on account of the presence of skatol, but contained nothing pathological beyond an excess of urates. Five days later I opened the abdomen, quite expecting to find a new growth somewhere in the large intestine. A median incision four inches long partly above and partly below the naval was made. The great omentum was seen to be adherent, and, on making a systematic examination, it was seen that there were three distinct tough and stringy bands of omental tissue attached, the lowest to the peritoneum at the appendectomy scar, the median to the parietal peritoneum, just beyond the colon and two inches above its head, and the highest to the parietal peritoneum, immediately beyond and below the hepatic flexure of the colon. In this way the distended ascending colon could be seen to be roughly divided by the bands into two pouches, the lower one below the level of the ileo-caecal valve, and the upper between that structure and the hepatic flexure. Evidently, what had been taking place was, firstly, a gaseous distension of the gut from fermentation, leading to pouching with further fermentative changes, particularly in the lower pouch, until finally the caecal pool became surcharged with irritants, and, in the next place, excessive peristalsis was set up, the bowel emptied itself and intestinal peace was restored. The cycle of events repeated itself again after about a fortnight. I divided these three bands, removing most of the intervening portion in each, and turned the free ends back on themselves, securing each with a single catgut suture to prevent readhesion. Except for a considerable amount of tympanities, which was combated with turpentine by

* Read before a meeting of the Queensland Branch of the British Medical Association on October 2, 1914.

the mouth and asafoetida and turpentine per rectum, the convalescence was uneventful, and the patient was discharged on March 25, 1914. I heard from him later that his bowel troubles are now a thing of the past, and that he was feeling quite like his old self.

Case II.—A.G.R., a railway employee, aged 26 years, came for advice on March 27, 1914, for abdominal discomfort, nausea and constipation. He gave the following history: Thirteen months ago, after several severe attacks of appendicitis he had his appendix removed in Warwick. He had never felt thoroughly well since the operation, and had much difficulty in securing a satisfactory movement of the bowels. He had even taken in one dose two packets of Epsom salts and half a box of a well-known brand of pills. Occasionally his abdomen became very distended, and he often felt "sick turns," as he described them, come over him—evidently sudden alterations of blood pressure in the splanchnic area, reflexly affecting the vomiting centre in the medulla, as I believe these "sick turns" to be. On April 4, after the usual preparation of the bowels by oil and enemata, I opened the abdomen through the sheath of the right rectus muscle, below the umbilicus, and found that a large portion of the great omentum was adherent to the parietal peritoneum at the site of the appendicectomy scar, to the parietal peritoneum external to the lower part of the caecum and to the lower end of the caecum itself. These adhesions were divided, and the cut ends turned back and secured (as in case 1). The patient made an uninterrupted recovery, and was discharged from hospital early in May, feeling quite restored in health.

Case III.—H.C., aged 31, a grazier, consulted me about six months previously on account of occasional attacks of abdominal pain and diarrhoea, both aggravated by horse-back exercise. The pain was felt chiefly around the umbilicus, but particularly at a point corresponding to the head of the pancreas and duodenum. When present, it was cramping in nature, and was relieved by rubbing and by the use of hot compresses. It ceased altogether when the diarrhoea, which always succeeded it, set in. History: About 12 years ago, whilst playing football in Melbourne, the patient was kicked in the abdomen between the naval and the right costal arch. Beyond being temporarily "laid out" and having subsequently to spend a few days in bed with sedative applications to the abdomen, no further ill effects were experienced until about three years subsequent to the injury. He then began to notice that his usual food occasionally disagreed with him, and that he often got slight "belly-aches." During the past three or four years the trouble had been growing in intensity to such an extent that 15 months ago he consulted a Melbourne specialist, who diagnosed mucous colitis, and treated the case with bismuth and ipecacuanha by the mouth, massage and colon irrigation. This course of treatment gave some temporary relief, and the patient returned to his home. Shortly afterwards, however, he became as ill as ever. Being desirous of embarking upon the matrimonial sea, he placed himself unreservedly

in my hands. Upon going thoroughly into his case, one could plainly see that the patient was intensely neurotic, and had made a profound study of all his symptoms. He had discovered, amongst other things, that the slightest trace of onion in his food would almost always bring on an attack of pain and diarrhoea. When one realizes how difficult it is, particularly when travelling, to avoid all traces of onion in food, one can easily understand how this state of affairs finally became almost an obsession. At the time of examination the patient's colour was good, tongue furred, teeth in splendid condition, and temperature and pulse normal. There was nothing abnormal to be felt in the abdomen, but it appeared to be fuller on the right than on the left side. The patient was tall, spare and muscular, and the abdominal reflexes very active. I told him that I thought his condition was principally of nervous origin, but that there might possibly be, in addition, a kink in the intestine. Operation: On April 6, 1914, I opened the abdomen through the right rectus muscle above the umbilicus, and soon found a thin, stringy band of omental tissue passing from opposite the antrum pylori to the parietal peritoneum, just beyond and below the hepatic flexure of the colon. This was divided between ligatures, and the stomach itself could then be seen to recede a little to the left. A careful examination revealed no other departure from the normal within the abdomen. The appendix was not removed, as it appeared perfectly healthy, and could not be conveniently reached through the original incision, which I did not care to extend. The abdomen was closed in three tiers and the patient made a rapid recovery. Owing to a mistake on the part of a nurse, a bowl of soup containing onion was given to this patient on the fourteenth day, with the result that a slight attack of diarrhoea came on, but no pain preceded or accompanied it. A diarrhoea of this type is undoubtedly of nervous origin! The idea of its being anything of the nature of anaphylaxis is, of course, quite out of court. However, since this episode, the patient has had no onion in his food and no diarrhoea, and when discharged from hospital was feeling perfectly well again.

Comparing these three cases, it will be seen that they have two points of similarity, viz., that the omentum was responsible for providing the constricting bands, and that an attack of inflammation was evidently the exciting cause, appendicitis in the first and second cases, and trauma in the third. One must look upon omental adhesions as being due to an attempt upon the part of the omentum to plug up or close off, as it were, some focus of leakage of intestinal contents through the bowel wall. The great omentum has not inaptly been described as the policeman of the abdominal cavity, and one must enter a protest against the indiscriminate manner in which some operators remove large portions of the great omentum, simply because it appears to be in the way. Truly the omentum can and will prove a friend in the hour of need. Exactly what it is that invites, as it were, more or less of the omentum to wall in an inflamed focus is difficult to say. It cannot be the attack of inflammation per se, for it

is by no means uncommon for an acutely inflamed and even gangrenous appendix to exist without even the slightest evidence of an attempt on the part of the omentum to form a protective covering, although it was quite long enough to reach the inflamed zone. In passing, let me remark that long and thin adhesions, as a rule, appear to give rise to more pain and discomfort than short and dense ones. The fact that even extensive omental adhesions may in time disappear completely was brought home to my mind very forcibly about three years ago in the case of a child of seven years, whose abdomen I opened over the right iliac fossa in the belief that she had chronic appendicitis with dense adhesions. Instead, I found what I took at the time to be an extensive sarcoma of the head of the caecum and attached omentum. I closed the incision and gave the parents a bad prognosis. Yet this child is to-day running about at home, and is the picture of health. The mass has quite disappeared from the right iliac fossa. Possibly it was a case of hyperplastic tuberculosis of the caecum, but at the time I saw no scattered tubercles, and the family history was particularly clean.

So much has been written in the journals of late about Jackson's membrane, Lane's kink and so forth, and so important is the question of constipation generally in the public eye, as witness the present craze for consuming liquid paraffin, that I have thought these few scrappy notes might prove of interest to some of you, though not perhaps to those whose experience of the operative aspects of intestinal stasis is not, like mine, limited to comparatively few cases.

In conclusion, those who would care to study the literature of peritoneal adhesions, I would recommend to peruse the recent article in the "Annals of Surgery" by Lewis Pilcher on "Pericolicitis dextra," and the chapter on peritoneal adhesions in "Practice and Problem in Abdominal Surgery," by Ernest Maylard.

Reports of Cases.

AN UNUSUAL FORM OF INTUSSUSCEPTION.

By C. Joyce, M.B., Ch.B. (Melb.),
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On September 10, 1914, a medical practitioner arrived at my house at 4 a.m., with his baby girl, aged 8 months. There was a history of attacks of pain of short duration for about 24 hours, and passage of bloody motions for six hours, but otherwise nothing pointing to any serious condition. The child did not have the appearance of being ill; the abdomen was relaxed, the only abnormality felt being a cord-like structure about the thickness of a little finger, extending from below the edge of the liver about one inch to the left of the mid-line, and disappearing into the pelvis below. No tumour having the characters of an intussusception could be detected; the cord-like band was obviously not of this nature. On making a rectal examination, the anus was easily dilated by the finger; no tumour could be felt in the rectum, but I noticed the sigmoid-rectal ring contract firmly around the tip of my finger. The finger was covered with bloody frothy mucus. We decided to perform an exploratory operation, and for this purpose the child was admitted into the hospital. Chloroform and ether anaesthesia was employed. The abdomen was opened

by means of an incision at the edge of the left rectus muscle. The cord felt at the exploration proved to be the large intestine collapsed, and drawn taut. On following it upwards I found an intussusception extending across the abdomen from side to side, and situated at the back of the abdominal cavity. The tumour was most resistant to the ordinary method of reduction, but when partly reduced I managed to withdraw it from the wound, but found that ordinary manipulations were quite ineffective. I therefore proceeded to combine with them traction on the ileum. In spite of having in my mind memories of numerous cautions that traction on the intussusceptum should never be employed, I was faced with the necessity either of doing this or of having recourse to resection of the tumour, or to incision of the outer sheath. The intussusception contained a button-like substance which was obviously causing too much resistance to allow of reduction without traction, combined with massage. As the tumour unfolded I saw the appendix and ileum emerge; the last part to be reduced was the head of the caecum, the wall of which was very inflamed, thick and hard, and was responsible for the button-like structure felt in the tumour. The wall had buckled inwards at the rounded end, and had been grasped by the contraction of the next portion of the caecum. This portion of the bowel had then been turned outside in; the ileum and the appendix were drawn in. The rest of the caecum, the ascending and transverse colon, and probably also portion of the descending colon were in turn pulled into the splenic colon, which was straightened out, and formed the outer sheath. Before reduction there was no constriction of the neck of the tumour; a finger was passed within it and could be followed alongside the ileum without difficulty. The mild character of the onset was due to the fact that until the end of the caecum had passed the ileo-caecal valve there was no obstruction of the intestinal canal. The mildness of the symptoms all through was due to the fact that there was no constriction at the neck, and though there was considerable congestion of the involved bowel it was attended to before any serious damage was done. The end of the caecum remained buckled inwards after reduction, but a little kneading restored it to its proper shape. In the first 24 hours after operation there was considerable shock, some vomiting and meteorism due to the length of time occupied by the manipulations, and two injections of pituitrin were given with excellent results, both on the general condition and on the condition of the bowel. Afterwards recovery was uneventful.

Treves mentions a form of intussusception in which a pouch forms in the wall of the intestine, but giving rise to little or no trouble. It seems extraordinary that I should have seen this form of the affection with most serious results fortunately averted by operation, twice in three years. I reported in the "Australasian Medical Gazette" three years ago a case in which a pouch formed in the wall of the colon, and into this a knuckle of small intestine was pushed, followed by nearly the whole of the small intestine.

Reviews.

VACCINATION.

Volumes such as Dr. Killick Millard's "The Vaccination Question" (1), which has just been published, serve to remind us that in the progress of scientific knowledge, no dogma, however well established or universally accepted, will escape critical examination. Those who would approach the question of the value of vaccination with a desire to ascertain the truth by the examination of each of the diverse opinions, will find this book exceptionally interesting. It is well written, and the author has shown great discrimination in the selection of his matter, and has succeeded in putting his views in such a way that their consideration is a pleasure, and not in the least

(1) "The Vaccination Question in the Light of Modern Experience; an Appeal for Re-consideration." By C. Killick Millard, M.D., D.Sc., 1914, London. H. K. Lewis, pp. 240. 20 Illustrations. Price 6s.

laborious. The book is in essence an exposition and a justification of what has come to be known as the Leicester method of attacking an epidemic of small-pox.

Dr. Millard removes any possible mis-apprehension as to his opinions on one of the fundamental aspects of the vaccination question, by stating emphatically that "Vaccination has, beyond all doubt, so far as the individual is concerned, a protective influence against small-pox." He states, "I regard this proposition as axiomatic," and goes on to say that in his opinion the duration of this protective immunity is probably about five years.

Having thus unequivocally and emphatically stated his conviction of the value of vaccination to the individual, he turns his attention to his main thesis, which is an examination of the question of the necessity or inadvisability of compulsory vaccination, applied to a community with the object of protecting that community against small-pox.

In the very nature of the case it was inevitable that this question should arise. Quite apart from other considerations, it is obvious that so long as small-pox is prevalent in a community to an extent which makes it a disease familiar to all, and which produces a heavy death-rate, so long will a preventive agent which offers protection remain largely unquestioned, and it is but natural that when the disease begins to decline in prevalence, the necessity of the continued use of the prophylactic should be questioned, whether this decline be the result of the use of that agent or the result of other influences, as for example, as is contended by Dr. Millard in the present case, by the improvement in sanitation.

This critical stage in the history of vaccination would seem to have been reached, and the question for examination is whether compulsory infantile vaccination offers sufficient security to the community to justify its continuance, or whether the community has available other equally satisfactory means of combating small-pox epidemics, and would be justified in discontinuing universal infantile vaccination.

Dr. Millard takes as the basis of his discussion the condition of England to-day, and eliminates other points which might be raised, as follows:—

"The effect of vaccination on a community depends upon the position of that community in regard to small-pox prevalence and small-pox prevention independently of vaccination. . . . The effect of vaccination even at the present day, in such countries as India or China, where the disease is endemic, will be totally different from what it is in this country. It is quite logical to suggest that it may be almost useless or detrimental here, although an incalculable boon there. . . . I am quite prepared to admit that a complete system of universal vaccination and re-vaccination and repeated re-vaccination, if such could be efficiently carried out, would abolish small-pox from any country in the world."

In other words, Dr. Millard takes up the position that, where the disease is endemic, and other sanitary measures are not applied, or perhaps applicable, universal infantile vaccination would be a means of very great value, and, moreover, that an effective system of repeated vaccination would remove small-pox from a community, while, on the other hand, in England, whereas compulsory infantile vaccination has not prevented epidemics, even amongst the vaccinated, and whereas a system of re-vaccination would not be tolerated by the community, and whereas other measures of equal value are available, or can be made available, the necessity for universal infantile vaccination no longer exists.

Dr. Millard goes still further, and attaches much importance to the fact that compulsory infantile vaccination is a positive danger, by reason of the fact that primarily vaccinated persons often develop a very mild attack, which may escape attention, or be wrongly diagnosed, and so act as a focus for further cases, thus commencing epidemics. This positive danger induces Dr. Millard to say, not only that the necessity for compulsory infantile vaccination no longer exists, but that the Vaccination Act should be repealed.

He offers as a substitute the administrative scheme which is known as the "Leicester method." This consists

in complete notification of all cases, or suspected cases, early isolation of cases in proper hospitals, surveillance of contacts, vaccination of contacts, and generally excellent administration. As it is proposed by Dr. Millard that this should form the sole plan of campaign against one of the most infectious of diseases, certain of his comments are worth noting. Speaking of the Local Authority under which he worked, he refers to the Chairman of the Sanitary Committee, who had occupied that position for thirty-seven years, and of him Dr. Millard says, "Sanitation in Leicester has been his life work, and he has spent himself unsparingly upon it." Again, speaking of his Chief Inspector, who had been Chief Inspector for twenty-three years, he says, "I have no hesitation in saying that much of the success of the 'Leicester method' has been due to his efficient and indefatigable work." When referring to the means of obtaining early knowledge of the cases during the 1903-1904 epidemic, he says: "The medical men in Leicester helped us loyally in the way of prompt notification, and would telephone to the Sanitary Office as soon as they had seen anything in the least suspicious."

From the information given in the book by Dr. Millard, it would seem that small-pox can be effectually dealt with in Leicester in the absence of any system of compulsory infantile vaccination, but the quotations given show that the administrative conditions in Leicester were favourable beyond the dreams of most other Medical Officers of Health. The satisfactory working of the Leicester system depends on a high degree of efficiency in health administration, not only during the epidemic, but in all routine work from year to year.

Dr. Millard has not anywhere in his book disproved the contention that compulsory infantile vaccination has in the past in England very materially diminished the amount of small-pox. Indeed, by inference he admits it, and most Medical Officers of Health will find great difficulty in deciding when their organization, and especially their system of notification of cases, has reached such a degree of efficiency, that they would feel justified in advising their authorities to concur in the repeal of the Vaccination Act. Dr. Millard's presentation of the case is stimulating, and his position has much to commend it, but it is very doubtful if the efficiency of the Leicester system has any parallel in Australia.

Notes on Books.

How the first Australian Expeditionary Force for the first time in history acting without any assistance from without, won a victory and captured a German colony is told in pictures by Mr. F. S. Burnell (1) in a most fascinating manner. The letterpress relates the facts necessary to render the pictures intelligible, and wisely avoids imaginative details or exaggerated accounts of the various phases of the expedition. Brief mention is made of the death of Dr. B. C. A. Pockley. The photographs are excellent and artistically taken. The little publication will serve as a delightful souvenir of Australia's achievements, and as a dignified memorial of our lamented colleague, Dr. Brian Antill Pockley.

Medical News.

QUEEN VICTORIA HOMES FOR CONSUMPTIVES.

We have been requested to bring to the notice of medical practitioners in New South Wales the following particulars in connexion with the applications for admission of patients into the Queen Victoria Homes for Consumptives at Thirlmere and King's Tableland, near Wentworth Falls, New South Wales.

Applicants resident in Sydney and suburbs.—Patients recommended by medical practitioners are required to apply

(1) "How Australia Took German New Guinea." An Illustrated Record. By F. S. Burnell, 1914. Sydney: Angus & Robertson, Ltd.; 8vo., pp. 34; 50 illustrations. Price 1s. 6d. (1s. 7d. post free) of all book-sellers.

personally for admission to the Secretary of the Homes, at the Board of Health, Macquarie Street, Sydney, at 3 p.m. on Tuesdays or Fridays. The applicants will be required to attend for examination by one of the medical referees at a specified time. These examinations will be made in the sequence of the applications. Those patients found suitable for treatment will be admitted within seven days of the examination.

Applicants resident in the country.—Applications are to be sent by letter addressed to "The Secretary, 7 Bligh Street, Sydney." A form will be sent for the medical practitioners in attendance to fill in. The medical referee judges from the information contained whether the patient is likely to be found suitable for treatment.

No persons will be admitted to the Homes unless they have resided in the State for a period of twelve months.

Other particulars have been set forth by Dr. Maclean in her very able article on the Thirlmere Sanatorium, published in the "Medical Journal of Australia," November 14, 1914, pp. 465-470.

THE MIDDLESEX HOSPITAL BLAND-SUTTON PATHOLOGICAL DEPARTMENT.

Through the munificence of Sir John Bland-Sutton, the Middlesex Hospital, London, is being provided with a most complete block of buildings for its pathological department. The building, which is of three stories, with a flat roof, occupies the northern side of the quadrangle at the back of the hospital. Accommodation is provided for a lecture theatre (capable of seating 150 students), a large, well-lighted museum, laboratories for bacteriological and chemical investigations, two large classrooms and several small ones for special workers, facilities for photography, rooms for receiving and preparing specimens, etc., in addition to offices for the director, the dean and others.

When completed and fitted up, this should form one of the most complete pathological departments attached to any of the London hospitals. Sir John is of opinion that much valuable material is lost through lack of proper examination. Dr. Carl Browning has been appointed director, and, as he has had control of the internal arrangements, everything should be adapted for the efficient working of the department.

The inaugural meeting of the winter session was held in the "museum" room on October 1, 1914, but the internal fittings of the whole block will not be completed until January, 1915.

An inscription, corresponding to the head of this note, appears on the front wall of the building, much against the wishes of the donor, who thinks is equivalent to erecting his "tombstone" before he is dead.

The Directors of the Pharmaceutical Defence, Limited, have issued their second annual report, which reveals a satisfactory state of affairs. The membership of the Society has increased, and now stands at 441. The majority of the members reside in Victoria. In the report, accounts are given of the various activities of the Directors, including a conference with the Federal Committee of the British Medical Association held in Sydney on February 3, 1914. This conference marks a very desirable tendency, and we hope that the pharmacists and members of the medical profession will keep in touch with each other and confer on all matters of mutual interest. The directors placed a recommendation on the notice papers of the Interstate conference (Sydney, February, 1914), pledging pharmacists to support any legislation restricting the treatment of syphilis to qualified medical men. The recommendation was endorsed, and the resolution affirming it was conveyed to the Federal Committee of the British Medical Association.

Naval and Military News.

According to the "Times," the health of the troops in camp in Great Britain is highly satisfactory. Sir Arthur Sloggett, the Director-General of the Army Medical Service, reports that the utmost vigilance is being exerted to maintain the favourable physical condition of the men. In order to ensure greater security, Lord Kitchener has

established a Sanitary Committee at the War Office, consisting of military and civilian members. Sir Arthur Sloggett has left for the front to make a thorough inspection of the medical arrangements, and to co-ordinate the work of the Army Medical Services with the St. John Ambulance and Red Cross Societies, of which he is the Chief Commissioner. He is accompanied by Colonel Burtchell, R.A.M.C., as Staff Officer. Sir Alfred Keogh is acting as Director-General during his absence.

A warning has been issued by the Local Government Board in England to the various Medical Officers of Health of districts in which troops are quartered that, under present conditions, a constant look-out should be kept for enteric fever, typhus fever and variola.

We learn that Dr. Hamilton Russell, of Melbourne, has been commanded by Lord Kitchener to proceed to Paris, and there to establish a large hospital on the lines of the Australian voluntary hospital. The success of the latter named hospital is recognized on all hands, and we have no doubt but that Dr. Russell will equip his Paris hospital in such a manner that it will prove equally valuable.

Dr. Alexander Palmer, of Dunedin, New Zealand, has been appointed to the Royal Army Medical Corps, with the rank of lieutenant, and is stated to have proceeded to the front. Dr. Palmer has been acting as a member of the resident staff of the London Hospital.

The hospital ship "Kyara," which is conveying the medical unit of the second and third Expeditionary Forces from Australia, met with fairly rough seas after leaving Sydney. A certain amount of sea-sickness was suffered, but in no case was the effect serious. On the morning of the second day out the prow of the vessel sank into a big wave. Several sailors, who were at work on the deck, were struck by the rush of water and were injured. One man had his right knee-joint opened, the wound extending vertically for about four inches, the patella and right femur being fractured. A second sailor received a diagonally situated lacerated scalp wound several inches in length, and squeezing of the chest. The edges of the wound were badly contused. No signs of intra-thoracic damage was made out. Both men received surgical treatment, and are progressing as well as can be expected. One of them has been sent to the Melbourne Hospital. A third sailor received various bruises which, however, were not serious.

University Intelligence.

ADELAIDE UNIVERSITY.

At a meeting of the Senate of the University of Adelaide, held on November 25, 1914, two substituted regulations concerning the bachelor of science degree were approved of. Under the old regulations, the candidates were able to take the subjects in any order they pleased. The clauses dealing with the course of study and sequence of examinations have now been rescinded, and the new regulations render it essential that students shall proceed in a prescribed order with each subject through the preliminary stage, and that they will not be admitted to any part of the advanced stage until the former has been completed.

Some important statutes have been approved of in connexion with the Alexander Clark Memorial Prize for music.

The results of the ordinary examinations for the degree of M.B., B.S., have been issued. The following is a list of successful fifth year students in the order of merit.

First Class.—None.

Second Class.—Haste, Reginald Arthur, B.Sc., and Turner, Charles Trevor (equal); Beard, Jack Roland Stanley Grose, and Wall, Frederick Laurence (equal); Smith, Walter Leonard.

Third Class.—Steele, Kenneth Nugent; Wibberley, Brian William, B.Sc.; George, Mildred May; Hayward, Lancelot Albert; Williams, Arthur Evan, and Cockburn, Patrick (equal); Guymer, Ernest Albert; Strachan, James Charles Power, and Gardner, John Forrest (equal); Godfrey, Kirke Charles.

Medical Journal of Australia.

SATURDAY, DECEMBER 5, 1914.

Amateur Health Administration.

A man was once asked whether he could play the violin. He replied that he did not know, as he had never tried, but he thought that he could. It would appear as if many of our municipal health authorities are in the same position in regard to hygienic matters. Last week we attempted to demonstrate the inevitable bungling which resulted when untrained and inexperienced persons undertook the management of a hospital. Unfortunately, no day passes without some fresh evidence of the essential mistake of the policy of allowing difficult administrative business to be conducted by a board of wholly incompetent amateurs. Two very striking instances are attracting the public attention at the present time. In both cases the public apparently realizes the incompetence of the authority concerned, but the only adequate remedy had not been suggested openly and unequivocally. The instances to which reference is made are the Infectious Diseases Hospital in Melbourne and the Health Committee of the City Council of Sydney.

The details in regard to the Infectious Diseases Hospital are well known, and have been dealt with in the "Medical Journal of Australia" in past issues. The evidence of the failure of the Board to fulfil its obligations to the public is to be sought in the refusal to admit cases of measles under conditions which may be described as urgent. The Board of the Hospital has attempted to explain its attitude in a statement published in the "Age" of November 24, 1914. The Board has "an intense sympathy" with the persons who are refused admission into the hospital; steps are being taken to remedy the present state of affairs by the erection of additional wards for the treatment of "complicated and special cases of measles"; it is "probable" that it will also provide for complicated cases of whooping cough at a later date; but at present "it is not a simple matter to admit such cases." The statement continues in this strain, and ends by a typical piece of self-praise for what it has already achieved. We

trust that the Melbourne public will not be misled by empty words. Intense sympathy is a very poor substitute for beds when the patient is suffering from an infective disease which requires careful and skilled treatment in the interest of the individual, and rigid isolation in the interest of the community. A hospital instituted for the purpose of assisting the health department to check epidemic disease does not perform its first function, if it fails to find accommodation for every case of these diseases. To speak of providing in the future for the admission of complicated and special cases of morbilli and pertussis is an admission of incompetence. What is required is the immediate erection of temporary wards for every case of every notifiable or infectious disease, pending the building of permanent blocks of wards. Not only complicated or special cases, but every case must find accommodation when adequate isolation cannot be carried out in the patient's home. Lastly, we are told that the provision of this accommodation is not a simple matter, but we imagine that it is not a simple matter to play a violin skilfully and artistically. The music-loving public would not tolerate the scratchings on a fiddle by an untrained individual, who excuses himself on the ground that real violin playing is difficult. Why should we accept this excuse in respect of the more important and vital matter of deadly diseases? The remedy is as simple as it is obvious. Ask the amateurs now playing at hygiene to try the violin, and engage a small body of experts who can and will carry out the necessary measures. Great Britain has led the way in hygienic matters since hygiene has become a science, and we must be jealous of our reputation.

The second instance of amateur bungling is perhaps still more instructive. Disposal of sewage and garbage has for years past occupied the attention of sanitary experts all over the world. In those cities where a satisfactory solution has been found, the health authorities have always allowed themselves to be guided by their expert advisers, and the controlling authority has exercised vigilance to prevent undue experimentation and risky methods from being resorted to. The city and other municipal councils of Sydney have been content to allow this highly important matter to take care of

itself. The easiest methods of disposing of refuse has been adopted. In the majority of instances the house and shop garbage and the street refuse is carried out for a short distance into the sea and cast overboard, to be washed up on to the nearest beach. Crude sewage is permitted to flow into the sea, while ventilation shafts from the outfall tell their tale to the discomfort of the inhabitant living to the leeward of the shafts. In other instances, dumping putrid matter into a "tip," such as that now becoming notorious at Moore Park, has been the simple expedient resorted to. The daily press has discussed this serious matter very fully, and numerous suggestions have been made as to the remedy. But while it is advisable to recognize which methods are bad and which have proved to be satisfactory, it becomes quite useless to recommend the adoption of a system, as long as our amateurs can do as they please. On November 26, 1914, this matter was discussed in the Legislative Council. Two or three points were brought out prominently. In the first place, the speakers appeared to be unanimous in their recommendation of the incinerator system. Secondly, they all condemned the Moore Park tip system. In the third place, agreement was arrived at in regard to the suggestion that the municipal authorities should be compelled to provide an efficient service, and, lastly, that at all costs the beaches must be kept clean. And while the legislators were discussing these ideals, the Health Committee of the City Council allowed a meeting to lapse because a quorum was not present. It is also stated that some of the aldermen are prepared to accept a ten years' contract with a firm for carrying out garbage beyond a 10-mile limit to sea. Mr. Flowers made the one sensible suggestion, namely, that this intensely important matter of the disposal of sewage and refuse should be entrusted to three "good men" for the whole of the metropolis.

Everyone has his own ideas in regard to every conceivable subject. The man in the street always has a remedy for a defect. In this particular case, the experience of the great cities in Great Britain and in other countries has been largely responsible for the general concensus of opinion that incineration is the best method of disposing of house and other refuse. It is economical, efficient and unob-

jectionable. Mr. Walshaw, the engineer in charge of the Sewage Station at Parramatta, who is an expert whose opinion is worthy of consideration, recommends the utilization of sewer gas generated in septic tanks for the purpose of incinerating the garbage, as well as for other purposes. But these suggestions are of small moment, unless the authority is expert enough to appraise their intrinsic value. From the public point of view, the question is not between one method of disposal and another, but between one public authority and another. This problem must be faced sooner or later, and the sooner it is solved the better for the health of the community. A drastic reform is needed, and it cannot be too drastic. We would therefore make the suggestion that all matters affecting the public health should be taken out of the hands of amateur boards, and that the control be vested in one body of experts for the whole Commonwealth, with dependant committees of experts in each State. The Federal solution of the problem should ensure uniformity, maximal efficiency and economy.

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A HEARTY SEND-OFF.

The Victorian Branch of the British Medical Association entertained on Saturday, November 21, 1914, a number of the medical officers of the Second and Third Expeditionary Forces, and expressed sentiments which the whole profession in Australia will echo and endorse. Dr. Kenny, the President of the Branch, paid a high tribute to those medical men, surgeons, physicians and specialists, who were offering their services to the Empire in its hour of trial. He proudly stated that Australia was giving her best, and they felt that her best was equal to the world's best. Sir Harry Allen supported the toast of "Our Guests," and said that those who were going away had their greatest goodwill, their greatest admiration, and their best good wishes. He hoped that they might do valuable work and have a safe return. About 80 of the Melbourne graduates were giving their services, which he regarded as a record to be proud of. He hoped that the cause for which the British soldiers, to whom they were going to minister, were fighting, would be crowned with success. Dr. Fetherston, the Director-General of the Medical Forces, spoke of the equipment, which he

said was very much finer than that laid down by the regulations. When they reached the field they would find everything necessary for a modern hospital. He wished them bon voyage.

In their replies, Dr. Syme, Dr. Bryant, Dr. Maudesley and Dr. Springthorpe thanked their hosts heartily for their enthusiastic reception, and for the good wishes of their colleagues. The speeches were full of patriotism and faith in the strong arm of the British Empire. In regard to the equipment of the hospitals, Dr. Bryant pointed out that they were taking with them a complete surgical outfit, X-ray apparatus, a motor ambulance and a telephone exchange for use in the big hospital. The authorities owed a debt of gratitude to Major Argyle for his very valuable services in securing the X-ray outfit and other equipment, which, he stated, the Government would have found difficulty in obtaining. An expert radiographer was accompanying the expedition, as was a skilled dentist. The services of both would be very valuable.

We have already sketched in outline the organization of the medical unit, with its regimental medical officers, ambulance service, clearing hospital, stationary hospitals and base hospitals, and have indicated the plan of dealing with the wounded from the time they are picked up in the field to the time they pass through their convalescence in an over-sea home. Last week we published a few radiographs of wounds inflicted by shrapnel shell or ball, which tell their tale much more eloquently than pages of descriptive letterpress could do. From the brief note sent by Dr. Herschel Harris, it would appear that, of the wounded men who reach the general hospital, well away from the fighting line, by far the larger number have been injured by fragments of shrapnel shell or rifle bullets. We learn nothing of bayonet wounds, although the records of the various battles contain accounts of hand-to-hand fighting with cold steel. In the Boer War the bayonet wounds in limbs were frequently met with, and as such were not necessarily fatal. Whether this obtains in the present war or not is unknown. The members of the medical unit leaving our shores will gain an experience of modern warfare, on a scale quite unparalleled in history. They will have to deal with surgical and medical

problems so new, so different from those met with under normal conditions, and so ghastly in their effects on the masses of fighting men that no conception of their nature can be formed beforehand. The medical profession throughout the Commonwealth will wait and watch for their comrades to return after peace has been declared. We hope to be in a position from time to time to publish some notes written by the various members of the departing force, descriptive of the experiences gained in the field and in hospitals. We wish all the members of the medical unit of the second and third expeditionary forces a useful period of activity, and a safe and happy return.

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CIVIL AMBULANCE AND TRANSPORT BRIGADE OF NEW SOUTH WALES.

The annual meeting of the Civil Ambulance and Transport Corps of the St. John Ambulance Brigade of New South Wales was held in Sydney on November 26, 1914, Sir Thomas Anderson Stuart presiding. The balance-sheet showed a deficit of £773 for the year. The number of legacies had been less during the past year than usual, while the subscriptions had fallen off considerably. In addition to this, the working expenses had increased. The Brigade had answered 8704 calls during the year, and upwards of 39,900 miles had been traversed by the ambulances. Sir Thomas pointed out that, unless more liberal support were forthcoming, it would be necessary to curtail the service. The work of the Civil Ambulance and Transport Brigade is of great value to the medical profession, as well as to the public. The service is well organized, and is prompt and efficient. The threatened curtailment would be deplorable, and we therefore venture to express the hope that the generous public will find ways and means to increase the treasury sufficiently to enable it to continue its good work.

MEASLES IN MELBOURNE.

At a meeting of the Melbourne City Council held on November 9, 1914, Dr. Cusaden pointed out that a short time ago he had attempted to obtain admission into the Infectious Diseases Hospital for a man who was suffering from morbilli, with a high fever. The man had just arrived from Tasmania by steamer and had no place where he could go. The hospital authorities refused to take the man in. He then applied to the Health Officer, in order to get the patient into the institution at Coode Island, but Dr. Robertson, acting on the instructions of the Minister for Health, also refused to admit the man. As a last resort, he had been able to place the patient on a steamer which was out of commission. Various councillors and aldermen expressed strong views on the subject, and it was finally decided that the Lord Mayor should communicate with the Minister for Health and with the Commonwealth authorities. It was pointed out that the ward which the Government had erected for the purpose of accommodating morbilli patients was wholly unfitted for the purpose, and a suggestion was made that the beds set aside for cases referred to the Infectious Diseases Hospital from the military camp at Broadmeadows might be utilized for this purpose.

Abstracts from Current Medical Literature.

THERAPEUTICS.

(218) Nascent Iodine Treatment.

E. G. Reeve ("Clinical Journal," August 19, 1914) gives an interesting account of the principles underlying the nascent iodine treatment, and the best method of its administration. He points out that small doses of potassium iodide are much more prone to cause the symptom-complex known as iodism than are larger amounts. This, he says, is due to the fact that the blood can only split up a certain limited amount of the drug in a given time. If an excess of potassium iodide be present, it acts in the same way in the blood as it does in a watery solution of iodine, i.e., by preventing volatilization and by increasing solubility. In the body the dissociation of iodine from its salt is most probably brought about by the action of ozone, which is carried by the hæmoglobin. Since this reaction is dependent on respiration, it proceeds at a uniform rate, however much potassium iodide there may be in the blood. Experiment has shown that iodism is most marked when 3 to 4 grains of potassium iodide are administered every four hours. By doubling the dose the symptoms disappear. From this it is concluded that large doses of the drug have no antiseptic power, whilst in doses of 4 grains or under the action is almost that of pure iodine introduced into the blood. This particular treatment aims at increasing the free iodine in the blood, whilst preventing the symptoms of iodism by means of the simultaneous presence of undissociated potassium iodide. This result is achieved by the administration of larger doses of the drug than can be normally oxidized by the ozone present, and dissociating it by the imbibition of chlorine water. If sufficient chlorine water be given to decompose four-tenths of the iodine, a solution containing twice as much iodide as iodine is formed; if four-sevenths of the iodide be decomposed, iodine and iodide are present in equal parts. Clinically, the practice followed is to administer the iodide first, and some hours later to give the chlorine water in divided doses, till the symptoms of iodism begin to appear. Twenty grains of potassium iodide are administered in ten ounces of water at breakfast time. Four hours later one ounce of chlorine water is given in one-half pint of lemonade, and repeated at intervals of two hours till three ounces have been taken. Slight iodism (headache and cold in the head) is apt to appear, but is relieved by the morning dose of potassium iodide, and disappears after a week or ten days. After three weeks, four, and then five, ounces of chlorine water may be given daily. The result of the treatment is well seen in acne, which first becomes more marked, proceeds to pustulation, and finally heals. Tubercular glands exhibit primary en-

largement, followed by subsidence. Similarly, laryngeal disease displays a primary hyperæmia, and subsequent improvement. About the third day of treatment the temperature rises, but, as a rule, falls again in a couple of days. During this period, malaise is present. Tubercular manifestations of all kinds, syphilis, malaria, mumps, gonorrhœa, rheumatism and several other affections have yielded to this form of treatment. Care must be taken in the preparation of the chlorine water. It is also advisable to give a large amount of water with the dose of iodide. If the chlorine water be administered too soon after the iodide, the patient's feelings may be harrowed by the expulsion of a large quantity of blue food and fluid from the stomach. If the chlorine water affects the patient's throat, it is better to give it in water rather than lemonade. The patient should be warned of the likelihood of the primary malaise, which is almost invariable. In the same issue, J. F. Hall Dally, another member of the Mount Vernon Hospital staff, also contributes a paper on this object. His technique is the same as Reeve's, and his results, especially in the treatment of tubercular cases, are quoted at some length. He also states that the treatment has proved very successful in some cases of asthma, and predicts a brilliant future for the method in the treatment of the hyperæmic states.

(219) Emetine.

George C. Low gives a concise account of the value of emetine in the treatment of amœbiasis, including dysentery ("Proc. Royal Soc. Med.," 1914, VII., 6). He traces the history of medication with ipecacuanha, and points out that the therapeutic value of the various plants is dependent on the emetine content of the root. The Brazilian ipecacuanha contains nearly twice as much emetine as the Columbian form. Emetine is a colourless, white powder, which darkens on exposure. It is readily soluble in alcohol, ether, chloroform, and benzine. It is a powerful emetic and expectorant, when given by the mouth. He adduces experimental evidence to show that both ipecacuanha and emetine have a marked amœbicidal action, which is directly attributable to the emetine content of the root. Quinine acts in a similar manner, but is not so powerful as emetine. Silver nitrate is still more powerful, but inasmuch as this salt combines with protein and is precipitated by sodium chloride, it cannot be used for this purpose therapeutically. Rogers recommends for acute and chronic amœbic dysentery, acute hepatitis and amœbic abscesses of the liver and spleen, an initial dose of one-third grain of emetine hydrochloride to be increased up to two-thirds grain. The results obtained were satisfactory. Low points out that under certain circumstances the amœbæ escape the action of the emetine just as the hæmatozoa of malaria at times resist the action of quinine and the spirochætes of syphilis resist the action of

mercury and salvarsan. He therefore gives emetine in half-grain doses (increasing up to 10 grains) by the mouth, if necessary in the form of keratin-coated tablets. Some patients tolerate these tablets without vomiting or discomfort; others are sick for a day or two, and then tolerate them, while the third group vomit after every dose. Low continues the medication for a long time, and when the drug is not tolerated by the mouth, he gives intramuscular injections. In conclusion, the author quotes Flandin's work on emetine in hæmoptysis and intestinal hæmorrhage. He gives 4 cgrs. dissolved in 1 c.cm. of distilled water. The action appears to be satisfactory.

(220) Carbolic Acid in Tetanus.

J. T. Fotheringham ("Canadian Med. Assoc. Journ.") records a case of tetanus in which carbolic acid injections appear to have had some part in determining the recovery of the patient. The author states that this result cannot be ascribed solely to the carbolic acid. The patient was a teamster, aged 18 years. He injured his foot, and a portion of the sole of his boot and of his sock was extracted from the wound, after suppuration had taken place. On the thirteenth day he noted some slight stiffness in the muscles of his neck and jaw. There was also difficulty in swallowing. On the seventeenth day 10 c.cm. of antitetanic serum was injected under chloroform anaesthesia into the spinal canal. A second dose of 20 c.cm. was given 16½ hours after the first. Chloral and bromides were given, and an injection of 1 drachm of pure carbolic acid in an equal quantity of glycerine into the subcutaneous tissue. On the following day four further subcutaneous injections of carbolic acid were administered; on the nineteenth day one injection, and on the twentieth day two injections were given. Some tumefaction and tenderness appeared locally in the sites of injection, but this cleared up within a few days. A careful analysis of the urine revealed the fact that no damage was inflicted on the kidneys. The effect of the treatment was a marked leucocytosis. One week after the last injection, all rigidity of muscles had disappeared, and the convalescence proceeded uneventfully.

(221) The Electrolytic Treatment of Lead Poisoning.

Kenneth Goadby ("Lancet," Oct. 3, 1914) has investigated the method advocated by Thomas Oliver of eliminating lead from the body by electrolytic means. This method of treatment of chronic lead poisoning was based on the assumption that the lead is present in the tissues in the form of a chloride or other inorganic salt. The treatment is carried out by immersing each of the limbs into a separate bath, and by passing a current of from 20 to 40 ma at a voltage of 16 through aluminium electrodes. Goadby substituted platinum for aluminium, on account of the iron content of the latter. He subjected 4 cats and

2 dogs to this form of treatment, after poisoning with lead nitrate applied intramuscularly in doses of 0.05 gm. per kilo body weight. In no case was any lead found on the electrodes after the current had been running for varying periods. One animal died of lead poisoning, and its liver was found to contain 0.0049 gm. of lead. The metal was in a condition of organic combination, as was proved by the fact that no deposit of lead was obtained prior to the destruction of organic matter. Further experiments demonstrated that a solution of 10 per cent. lead nitrate, when brought into contact with a 5 per cent. solution of egg albumin, behaved in a similar way. The lead was obviously in the form of an albuminate, and no metal could be deposited from the solution by electrolytic means. After treatment with strong nitric acid and potassium chlorate, all the organic matter having been broken up, the lead could be deposited on the electrodes without difficulty. Goadby has therefore come to the conclusion that the experiments in vivo and in vitro give no support to the contention that lead is eliminated from the animal body by electrolytic methods. W. H. F. Oxley (*ibid.*) has also dealt with the same subject, and has attempted to remove the blue line on the gums of workers in lead by Oliver's method. In this he failed. Not a trace of lead was deposited on the electrodes after the application of the treatment. He is of opinion that no practical good would result from the regular treatment of lead poisoning by electrolysis. He contends that there are two reasons why an electric current could not remove from the superficial layers of the skin more than a minimal trace of lead. In the first place, the tissue ions use up a large proportion of the total current. It has been found that in a solution of mixed electrolytes, all the electrolytes take part in the migration towards the poles, but that the ratio of concentration of ions does not undergo any change. The second reason is the slow rate of penetration of ions through the skin.

UROLOGY.

(222) Surgical Treatment of Multiple Cysts of the Kidney.

Mickaniciowski ("Journ. d'Urologie," May, 1914) deals with the subject of the operative treatment of multiple cysts of the kidney and the somewhat disappointing results. The condition, as such, cannot be cured by surgical or other means, since it is bilateral, and since it depends to a large extent on a chronic nephritis, which leads to the formation of cysts. It is quite obvious that these changes are not amenable to operative interference. The object of surgical treatment is therefore palliative. Operation may be undertaken for the following reasons: If there are severe attacks of pain, if the tumour compresses the intestine, giving rise to disturbance of function or obstruction, if hæmaturia sets in, if there is any suppuration, if the kidney

is movable, especially if this be associated with pain, and if hydronephrosis be present. Before any operation is carried out it is necessary to perform ureteral catheterization and to carry out a functional examination. Provided that the other kidney is found to be normal, nephrectomy may be regarded as justifiable for movable kidney, if fixation cannot be performed. When the function of the other kidney is not quite normal, conservative operations may be taken into consideration, but not nephrectomy, save in the case of suppuration. In the treatment of cystic movable kidneys, the author recommends nephropexy, combined with decapsulation and excision of the cysts. He advises partial nephrectomy, that is, decapsulation and excision of the cysts in all other cases. Simple puncture or incision of the cysts is of no value.

(223) The Prognosis in Chronic Nephritis.

Widal calls attention to the value of the estimation of the urea content of blood in determining the prognosis in cases of chronic nephritis ("Journ. d'Urologie," June, 1914). It is possible by this means to determine the amount of retention of nitrogen which cannot be estimated by the determination of the urea content of the urine. Widal is of opinion that the measurement of the blood urea enables the urologists to demonstrate which symptoms are due to increased nitrogen, which are due to retained chlorides, and which are due to increased arterial tension. The knowledge thus gained enables him to form a reliable prognosis in regard to the course of the disease. As a result of a large number of estimations, the author has come to the conclusion that when one to two grammes of urea are present in the blood, the patient rarely lives more than one year. If from two to three grammes are found, he may live for a few weeks or a month or two; while if more than three grammes are present, death is imminent. In a few cases he found quantities up to eight grammes immediately before death. The prognosis is doubtful when between a half and one gramme is found. In these cases repeated examination is required, and should be carried out at longish intervals and with varying diet. A gradual, steady increase of the urea contained in the blood is a bad sign. The author attempted to ascertain whether a reliable prognosis could not be made from a single observation on the basis of the formula of Ambard's constant. He was, however, unable to come to any definite conclusion.

(224) Traumatic Nephritis.

Prusson ("Journ. d'Urologie," June, 1914) discusses the pathology of certain forms of traumatic nephritis, and makes special reference to a number of cases published in various journals. He is inclined to the opinion that mild acute nephritis is fairly common, as a result of bruising of the kidney. The condition can be recognized by the presence of albumin, casts and blood

corpuscles in the urine. Cases of this class are usually cured by appropriate treatment, and rarely pass over into a chronic form of nephritis. Sub-acute traumatic nephritis ending fatally is rare. It has frequently been denied that chronic nephritis can develop as a result of a trauma, but Prusson cites 13 cases of undoubted traumatic chronic nephritis. One of these cases was observed by himself. In all 13 cases other causes of nephritis, e.g., alcoholism, etc., could be excluded. The trauma was very severe in each instance. Hæmaturia occurred shortly after the accident in the majority of cases, and was accompanied by fever, and other symptoms of sub-acute nephritis. He points out that œdema is not infrequently observed. This œdema is limited to the injured side, and is probably due to a vasomotor disturbance. In four cases the condition of each kidney was determined by ureteral catheterization and functional examination, and it was found that the function of the damaged kidney was materially impaired. The diagnosis was confirmed after death in several cases. The uninjured kidney at times was found to be affected. This may be explained on the basis of a renal reflex and consequent disturbance of nutrition, or by the result of nephrotoxins. It has been experimentally demonstrated that nephrotoxins are produced by the destruction of renal cells.

(225) High Frequency Currents in the Treatment of Vesical Tumours.

Denos ("Journ. d'Urologie," June, 1914) recommends the endovesical treatment of papillomata of the bladder very strongly. He finds that these growths can be removed with facility by means of high frequency currents. One of the chief advantages of this method is the fact that it exercises a hæmostatic effect, even in malignant growths. In three of his patients he succeeded in arresting the hæmorrhage immediately by the use of high frequency currents, after all other means had failed, and the patients had almost bled to death.

(226) Pneumaturia in Renal Tumours.

W. Israel ("Zeitschr. f. Urologie," June, 1914) records a very rare case of pneumaturia due to a malignant renal growth. The patient was 63 years of age, and had had three severe attacks of hæmaturia with blood casts in the course of two years. A renal tumour of the size of a child's head was felt. The tumour showed fluctuation, and there was intermittent pus and gas in the urine excreted. Fever was present. Nephrectomy was performed, and resulted in complete recovery. At the lower pole of the tumour there was a disintegrating cavity of the size of an ostrich's egg, from which blood, pus and sulphuretted hydrogen gas escaped.

Contract Practice

VIII.

The Origin of the Common Form of Agreement.

The Branch Council of New South Wales was placed at an early date in a favourable position for remedying the defects which had crept into contract practice within the State. Between 1900 and 1907 it was recognized that the main reforms must have reference to the minimum rate of remuneration, and to the limitation of contract attendance to persons whose incomes were insufficient to allow of the payment of ordinary private fees. In 1907 the Branch adopted the principle that no member should be accepted on the list of any lodge doctor if his income exceeded £200 per annum. It was further held that any member of a lodge who attained an income of £300 per annum or over during the course of his membership should be excluded from receiving medical attendance at the ordinary rate. This principle was affirmed by a resolution of the Australasian Medical Congress, held in Melbourne in November, 1908. In February of 1909 this arrangement of the income limit was brought into force in Sydney and its suburbs; the arrangement, however, was not retrospective. In 1906 the Branch drew up a form of agreement for use by its members in entering into any arrangement with a friendly society. This agreement included an income limit clause and provisions for the regulation of the relations between the medical officers and the lodges, and between the medical officers and the patients. This form was published in the "Australasian Medical Gazette" on September 20, 1906. It was approved by the Council and the Branch in November, 1906, was amended by the Branch in May of 1907, after a conference had been held between the Council of the Branch and the Representatives of the Friendly Societies' Association. It is unnecessary to dwell on the negotiations which led up to the adoption of this early form of agreement. The principles underlying the agreement appealed to the members throughout the State, and in 1909 each of the affiliated local societies set to work to draw up a form of agreement on the pattern of the 1906 agreement. Throughout these years the members of the Association in all parts of the State began to realize the urgent necessity of submitting to a central control, and of accepting the policy agreed upon by the Council and the Branch. Without ostentation or publicity, the organization of the medical profession within the area of the Branch proceeded during the whole period from 1906 until in 1912, when an opportunity presented itself which led to a striking advance. The Chief Secretary, Mr. Flowers, had invited the Friendly Societies and Dispensaries to send delegates to a conference for the purpose of discussing the advisability of the establishment of State-supported dispensaries. It was determined at this conference that other matters affecting the Friendly Societies should be discussed. There were four sessions held toward the end of July and during the first half of August, 1912. Mr. Flowers presided, and led the delegates to discuss without reserve the relations between the Friendly Societies and the British Medical Association in New South Wales. The opinions expressed at this meeting are full of interest, and illuminate the whole matter from the point of view of the organizing laymen. As was to be expected, some of the delegates adopted an attitude which was frankly hostile to the British Medical Association. On the other hand, a certain number of members, including some of the most powerful officials of the various bodies, showed considerable sympathy with the attitude adopted by the Branch. The Grand Secretary to the Manchester Unity Independent Order of Oddfellows described the British Medical Association as a union, and a very good union. He stated that there was something wrong with the men outside the British Medical Association, and he appealed to the delegates present, who were, to a large extent, members of trade unions, to approve of the policy of refusing to employ medical blacklegs. Some of the delegates admitted that the friendly societies were sweating the doctors; others maintained that the doctors were receiving very fair treatment. The outcome of a highly interesting and many-sided debate was the passing of a resolution that the British Medical Association be

invited to meet the delegates of the friendly societies in a conference, with the assistance of Mr. Flowers. It appears that the perspective of the delegates was limited to the narrow scope of individual convenience. Not a single member illuminated the question from the point of view of public policy. No one appears to have recognized that contract practice is a means of providing the masses with medical attendance, with which the individual wage-earner could otherwise not well afford to provide himself. It thus appears that contract practice is an instrument for safeguarding the health of that section of the community which is not well-to-do. Inasmuch as the efficiency of the treatment accorded at low contract rates to this section of the community must depend on the limitation of the amount of work required on any given practitioner, it follows that all abuse of the facilities for obtaining treatment in this manner by persons who are in a position to pay full fees must operate detrimentally to the interests of the bona-fide lodge patient. In addition, if the conditions of practice are such as to render the life of the practitioner irksome, the satisfactory relations between patients and doctor, which are so essential to successful treatment, will be wanting. The delegates of the friendly societies should therefore have recognized that by demanding the adoption of an income limit, a reasonable rate of remuneration and suitable conditions of practice, the medical profession was merely indicating the conditions under which efficient treatment of the wage-earning class could be ensured.

On September 14, 1912, Mr. Flowers presided over the first conference between the delegates of the Friendly Societies and those of the New South Wales Branch of the British Medical Association, and the result was that a committee of eight was appointed, with four members representing the Friendly Societies and four members representing the British Medical Association, for the purpose of considering the points at issue, and of suggesting a plan which would receive the support of both parties. The "Australasian Medical Gazette" only devoted some dozen lines to this conference, but it appears that through the skillful handling of the meeting by Mr. Flowers, the Friendly Society members were placed in a position to understand the justice and advisability of the demands made by the profession, and were prevailed upon to consider the various proposals in an unbiassed manner. On September 27, 1912, Mr. Flowers again presided at a conference, at which a draft form of agreement was considered and approved. This form of agreement was in effect an agreement which had been drawn up by the North Eastern Medical Association. Concessions were made on both sides, but the Association delegates insisted on the recognition of the principle of an income limit, increased rates and mileage allowance. In the city of Sydney, the minimum rate was to be 19s. In the suburbs a 21s. rate was introduced, while the question of the country rate was not decided. The New South Wales Branch subsequently determined that the country rate should be 26s. without medicine, or 34s. with. Mileage was to be paid for at the rate of 5s. per mile outside the two-mile radius and 7s. 6d. at night time. No one can suggest that these rates are unduly high. When compared with the payment made under the National Insurance Act in England they may be regarded as too low. It was determined that the Draft Agreement as amended should be submitted to the respective societies for consideration.

In 1913 the Draft Agreement, known throughout the State as the Common Form of Agreement, was considered by a meeting of the Branch, and also by meetings of each of the Local Medical Associations. It received the approval of the medical profession throughout the State.

British Medical Association News.

SCIENTIFIC.

A meeting of the New South Wales Branch was held on November 27, 1914, at the B.M.A. Building, 30-34 Elizabeth Street, Sydney, Dr. David Thomas, the President, in the chair.

Dr. Burton Bradley demonstrated by means of photomicrographic lantern slides a series of interesting new growths. The first tumour was derived from the ovary of

a patient of Dr. Kelly. Dr. Kelly was unfortunately prevented by illness from reporting the clinical history of the case. In brief, the history was that the woman (of middle age) sought assistance for an increasing swelling of the abdomen. A definite tumour was felt in the lower part of the abdomen. At the operation, the main part of the growth was represented by a large mass, involving the ovary; secondary deposits were found in the peritoneum, liver and other situations in the abdomen. Dr. Bradley examined a portion of the primary ovarian tumour. The growth was about the size of half a man's hand; it was of softish consistency and whitish colour. The macroscopical appearance suggested that it was a sarcoma. On microscopical examination, it was found that it consisted of cells suggesting an epithelial origin; there was, however, no distinct tubular structure. The epithelioid cells were associated with a supporting tissue, but in this particular case it was almost impossible to determine whether the supporting tissue was placed between the individual cells or between groups of cells. Even in the specimens stained by the iron-haematoxylin method, it was difficult to determine this point. The cells were in part multinucleated. They were irregular in shape, and the nuclei frequently stained very darkly. Mitosis was not well marked, but this was regarded as being due to the state of degeneration of the tumour. In parts of the tumour there were cells of the mixed type, and, in other parts, the structure looked as if there had been at one time distinct tubular formation. He tended to the view that the tumour cells had their origin in some form of epithelial cell, but he was not prepared to commit himself as to what tissue this was. The lantern slide showed the characters of the growth.

The next tumour shown was one which has been recorded at a previous meeting of the Branch (see "Medical Journal of Australia," October 17, 1914, p. 389). The tumour was a nephroma, and the salient point of interest was found in what Dr. Bradley regarded as newly-formed tubules. The main structure of the tumour was made up of round and spindle cells, like sarcoma cells, with some cells of an epithelioid type, and intersecting strands of fibrous tissue.

Dr. Bradley also showed slides of the microscopical appearances of another tumour which he had described at the previous meeting referred to (l.c.). This tumour was found in the fatty tissue surrounding the breast and was regarded by Dr. Bradley as originating in a sebaceous gland. He demonstrated the marked stippling of the cells, the endothelial nature of the growth and the formation of the small tubercle-like masses. Under any circumstances, the growth was of low malignancy, and its characters were highly suggestive of an endothelioma. In certain areas, distinct giant cells with a very large number of nuclei were pointed out, as were clumps which Dr. Bradley regarded as cells' nests.

He also showed a section of an angio-melanoma, the distinctive characters of which, however, were not as well seen in the slide as in the original microscopical specimen.

Lastly, Dr. Bradley gave an account of a tumour of the brain, and demonstrated both the tumour itself, and also lantern slides of the photomicrographs taken of the sections. The history was given later by Dr. S. A. Smith (see below). The intra vitam diagnosis had been tumour of the pituitary body. The patient was admitted into the North Shore Hospital in a dying condition. At the post mortem examination it was found that the pituitary gland was not directly involved, and that it was normal in size and shape to the naked eye. A tumour of the size of an egg was seen pressing on the optic chiasma, bulging into the ventricle and lying in contact with the infundibulum and pituitary stalk. It was yellowish in colour, but in one or two places, the colour was deeper. On microscopical examination, it was found that the growth contained large interspaces, with more or less dense cell aggregations, the spaces being filled with material containing varying amount of definite structure and cellular elements. These masses were like colloid filling the alveoli of a thyroid gland, but in places the material was definitely organized. Some of the cells seen were undoubtedly brain-cells undergoing vacuolization. In the inter-alveoloid tissue, the cells were seen to be arranged almost in tubular formation. There

was but little doubt from the structure of the growth that the origin was from epithelial or endothelial structures, and it had the appearance as if it had originated from the pituitary body. Many of the cells were exceedingly like squamous epithelium, and Dr. Bradley was of opinion that the tumour might have arisen from the remains of the primitive canal connecting the pituitary body and the mouth. Under any circumstances, it was not a psammoma or glioma. He was inclined to describe it as an endothelioma arising in the manner stated.

Dr. Ayres stated that he had had an opportunity of seeing the patient some time before death in St. Vincent's Hospital. The patient was very frail and weak at the time. The diagnosis of pituitary tumour had been suggested, and he therefore took two radiograms of the sella turcica. The first picture was unsatisfactory, as the patient had moved. The second one was quite distinct, and did not reveal any tumour of the pituitary body. In order to demonstrate this clearly he had prepared another radiogram of a boy who was not suffering from any cerebral condition, but, unfortunately, Dr. Smith had not brought the negatives with him. He was much interested when he learned that no tumour of the pituitary body had been found post mortem.

Dr. S. A. Smith gave an account of the clinical history of the case. The patient was a school teacher, aged 41 years. She had been perfectly well until the age of 39, when she noticed that her eye-sight was beginning to fail. Her attention was first called to this immediately after a very severe thunderstorm, when a man was killed within a short distance of the spot where she was standing. She wore glasses sold to her by an optician, but these did no good. On consulting an ophthalmic surgeon, nothing pathological was found in the eyes; the defect of sight was ascribed to her general condition of health. Twelve months later, her general health began to fail, and she became much emaciated. She lost her appetite, became quite apathetic, in spite of the fact that she had hitherto been a very energetic and intellectual woman, her sight failed her more and more, and her memory became defective. Dr. Shepherd saw the patient, and found that the discs were atrophic-looking and that there was a bi-temporal hemianopsia. The sight of the right eye was almost lost. She did not suffer headache, nor was there any vomiting. The temperature was subnormal, but the pulse was of poor quality, low tension and rapid rhythm. Examination of the various systems yielded a negative result. She was admitted to St. Vincent's Hospital, for observation. The diagnosis of probable pituitary or supra-renal tumour was made and an examination by X-rays was undertaken, but with doubtful or negative result. She was, nevertheless, given pituitary extract. The first few doses were injected subcutaneously, but later, the extract was given by mouth. At that time she was confined to bed, was extremely ill, languid and weak. The result was most striking. Within a short time she was able to get up, her appetite returned, she became mentally brighter and more energetic, and was undoubtedly much better. She insisted on leaving the hospital. An operation was offered, but refused. After about three months, she exhausted her supply of pituitary extract, and some delay was occasioned before more was procured. During this time, she got very much worse. Dr. Smith subsequently learned that she had been admitted to the North Shore Hospital in a moribund condition, and that she died shortly after. He discussed the clinical aspects of the case, and emphasized the absence of symptoms pointing to cerebral tumour. He regarded the case as one of hypo-pituitarism of a qualitative, if not a quantitative, nature. The extraordinary reaction to pituitary extract supported this view. The post mortem find was not against this view, inasmuch as while the pituitary gland was apparently normal, the infundibulum and stalk had been compressed, and there was evidence of absolute occlusion.

Dr. Sandes asked whether there were any signs of disturbance of the vaso-motor centres; to which Dr. Smith replied in the negative.

In discussing the renal tumour shown by Dr. Bradley, Dr. Litchfield remarked that these growths were usually spoken of as hypernephromata. The nature of the tumours had recently been described by Pott, who used the term

blastocytoma for the condition. Blastocytes, as contrasted with epicytes, were indifferent cells, which might develop into mesoblastic or epiblastic elements. Blastocytes could therefore give rise to round cells, spindle cells or epithelial cells, and the specimens of this author showed that even tubular formation could arise in this manner. In some of his cases, there was an elementary development of glomeruli, thus indicating that the tumour was derived from organ or tissue cells. Dr. Litchfield was of opinion that the tumour demonstrated by Dr. Bradley was of this nature, and should therefore be referred to as a blastocytoma.

Dr. Bradley agreed with this, and expressed the view that the cells of origin of the tumour were indifferent cells, from which the quasi-sarcomatous growth had taken place.

MEDICO-POLITICAL.

At the same meeting, Dr. R. H. Todd, the Honorary Secretary of the Branch, moved on behalf of the Council:—

"That the following be regulations of the Branch regulating attendance under contract upon members of Friendly Society Lodges."

The regulations referred to were submitted to the meeting in draft. Dr. Todd explained that at a previous meeting these draft regulations had been received, and the discussion on the resolution postponed, in view of the fact that some points were perhaps not quite uncontentious. There were twenty clauses; nineteen of them were definite re-statements of what was at the present time being carried into effect. The Council held it to be advisable to embody those resolutions of the Branch and of the Affiliated Local Societies, which affected Lodge practice, in hard and fast regulations, and, insofar as these nineteen clauses were concerned, he assumed that no opposition would be raised. It had been pointed out at the previous meeting that Regulation XI. was not likely to find general acceptance. The wording was as follows:—

"No member shall examine any applicant for admission to the medical benefit of a Friendly Society Lodge who does not bring to him a statement in writing from the Secretary of the Lodge to the effect that he or she is entitled to such medical benefit according to the terms of the Income Limit Clauses of the Common Form of Agreement, and who shall not have signed the following Form of Certificate, duly completed, viz.:—" (Here followed the form, giving particulars of the member and of all persons dependent on him who would be entitled to receive medical attendance in virtue of his membership, and also setting forth that the member understood the nature of the Income Limit Clauses.)

Dr. Todd pointed out that it was essential that a medical officer of a Lodge should know what his risks were in regard to the persons who could claim medical attendance of him. Experience had shown that the number of dependents who had this right was considerable, and that the medical officer would be required to look after approximately 434 persons for every member on his list. A man with 100 members on his list would therefore have to attend between 400 and 500 persons. He should know who these people were. Moreover, the Council thought that there should be documentary evidence that the member had understood the terms of the Income Limit Clause, and should subscribe to the statement that at the time of joining his total income together with that of his wife did not exceed £208 per annum.

Dr. Spiller Brandon seconded the motion, and thought that the introduction of this form, governed by regulation eleven, was valuable, provided that the medical officer could retain it and perhaps hand it over to the Branch, in order that the information might be available for other officers who might subsequently follow him. He proposed that the forms should be printed in book form, to be retained by the Medical Officer, and not be handed over to the Lodge.

The President, Dr. Thomas, explained that this was the intention of the Council and Dr. Todd produced a book of forms.

Dr. C. E. Corlette wanted to know how Regulation VIII. could be given effect to, inasmuch as the men never knew

who the other medical officers were. The regulation reads as follows:—

In the case of a Lodge having more Medical Officers than one, all of whom lose their positions in consequence of any resolution of the Branch or of the Council, none of them shall accept re-appointment unless all are re-appointed."

Dr. Todd was able to state that this regulation was already in use. A complete list of the Medical Officers of the various Lodges was kept in the Office, and this information was made available to the members when the occasion indicated in the regulation arose.

Dr. Woolnough objected to Regulation XI. on the ground that it prohibited medical officers from examining candidates for membership of a Lodge unless the certificate from the Secretary was produced, and unless the form was filled in and signed. He thought that the introduction of the form was premature, and suggested that, in its stead, at all events for the present, a simpler form might be substituted, and that its employment should be made optional. As an alternative he proposed that the form might be used at the discretion of the members, and that the regulation be so amended as to make this a recommendation and not a mandate.

Dr. Lipscombe spoke strongly in favour of the regulation. He had had twelve years' experience of Lodge practice, and was quite convinced that its general adoption was highly desirable.

Dr. Todd did not wish to press the paragraph in respect to the form, and therefore suggested that all the words after "Common Form of Agreement" might be deleted. Dr. Woolnough moved this as an amendment; Dr. Todd seconded it, and, on it being put to the meeting, the President declared the amendment lost. The original motion was then put to the meeting, and was carried.

The annual meeting of the Queensland Branch will be held in the B.M.A. Rooms, Brisbane, on Friday, 11th December, 1914, at 8.15 p.m.

Dr. Brockway will move:—

"That the rules of the Branch be altered to allow of the appointment by the Council of one or more Honorary Vice-Presidents selected from the country members."

Dr. E. Culpin will move:—

"That the Commissioner of Public Health be requested to amend certain regulations of the Private Hospitals Act dealing with puerperal fever as early as possible."

Dr. Kerr Scott will move:—

"1. That in the opinion of the Branch, the display of the Red Cross on vehicles driven by or conveying medical practitioners is advisable."

"2. That steps be instituted to obtain permission and recognition of the Traffic authorities."

The Acting-President will address the meeting, and the Acting Honorary Secretary will present the Council's report for the year, and the Treasurer's Statement.

The election of officers for 1915 will conclude the business.

BRITISH MEDICAL ASSOCIATION (AUSTRALIA) MILITARY MOTOR AMBULANCE FUND.

The Honorary Secretary of the Federal Committee of the British Medical Association (Dr. G. H. Abbott) reports that the small sum of £87 17s. 6d. has been received during the week ending 1st December, 1914. Only 58 names appear on the list. We would again draw the attention of the members of the Association to the fact that the appeal is being made to the patriotic feelings of Australian and English practitioners in the Commonwealth, and that the Federal Committee still entertains the hope that a large proportion of the members will contribute something to the fund. The total up to date is £834 13s.

Fourth List.

	£	s.	d.
Dr. Bertram, Hussey, Q...	1	1	0
" Jamieson, Stanley, Yarrowonga, Vic...	1	1	0
" Morton, A. E., Worsley, W.A.	1	1	0
" Mead, Gertrude, Perth	0	10	0
" Clarke, P. G., Portarlington, Vic.	1	2	0
" Joske, A. S., Prahran, Vic.	1	1	0

Dr. George, Isaac, Mornington, W.A.	1	0	0
Thomas, H. D., Caulfield, Vic.	0	10	6
McDouall, J. A., Gladsville	1	1	0
Tomlinson, W. R., Sydney	1	1	0
King, C. E., Kalgoorlie, W.A.	2	2	0
Greig, Janet L., Melbourne	1	1	0
Harris, John, Sydney	1	1	0
Maclean, James, Chatswood	2	2	0
Mollison, C. H., Melbourne	1	1	6
Hutchinson, E. L., Wee Waa, N.S.W.	1	1	0
Anonymous	10	0	0
Vickery, K. F., Sydney	1	1	0
Anderson, Arthur, Goondiwindi, Q.	1	1	0
Sweet, Elizabeth M., Brisbane	1	1	6
McDowall, St. A., Oakey, Q.	1	0	0
Bonnin, F. J., Ararat, Vic.	3	5	0
Bourke, James J., Richmond, N.Q.	2	2	0
Collins, V. E., Port Douglas, Q.	1	2	0
Nickson, Wilfred, Newcastle	1	1	6
Tregear, G. H., Victoria	1	1	0
Dennis, C. E., Melbourne	1	1	0
Maw, H. S., Tumbarumba	1	1	6
Pern, H., South Gippsland	2	2	0
Wilkinson, A. M., Glenferrie, Vic.	1	2	6
Kenny, A. L., Melbourne	2	3	0
Sprod, Milo, Mannum, S.A.	1	1	0
Gunson, J. B., Adelaide	1	1	0
Sinclair, T. W., Melbourne	1	0	0
Gollan, L., Ulverstone, Tas.	1	1	0
Feige, A., Wayville, S.A.	1	0	0
Ott, August, Ayr, Q.	1	1	6
Millett, W. L., North Queensland	1	1	0
Chenhall, W. T., Sydney	2	2	0
Gillies, Sinclair, Sydney	5	5	0
Gibbs, R. H., Colac, Vic.	1	2	0
Smellie, W., Penguin, Tas.	1	1	0
Bennett, H. V., Prahran, Vic.	1	1	0
Jones, S. Evan, Parramatta	1	0	0
Naylor, A. G. E., Loch, Vic.	1	0	0
Goode, M. E., Port Pirie	2	2	0
Campbell, T. S., Aramac, Vic.	2	0	0
Shaw, F. C., Wyalong	2	2	0
Douglas, J. C., Adamstown	1	1	6
Benham, Rosamond, Queensland	1	1	0
Hart, Basil, Ipswich	1	1	0
Hayward, Lionel, Loxton, S.A.	1	2	0
West, G. R., Kaniva, Vic.	2	3	0
Hughes, M. O. G., Sydney	1	1	0
Ramsay, J., Launceston	2	2	6
Watson, J. W., West Wallsend	1	1	0
Schlink, H. H., Sydney	1	1	0
Bonnin, J. A., Hindmarsh, S.A.	1	2	0
Curtin, A., Grenfell	1	1	6

Public Health.

SMALLPOX IN SYDNEY.

The number of smallpox cases reported to the Department of Public Health, New South Wales, during the week ended November 29, 1914, was:—

City of Sydney and Metropolitan District	11
Country—	
Penrith	1
Total	12

THE HEALTH OF VICTORIA.

During the fortnight ended November 24, 1914, the following returns have been received from the Department of Public Health, Victoria:—

	Pulmonary			
	Enteric Fever.	Diphtheria.	Scarlet Fever.	Tuberculosis.
Whole M'tro- State, polit'n.	Whole M'tro- State, polit'n.	Whole M'tro- State, polit'n.	Whole M'tro- State, polit'n.	Whole M'tro- State, polit'n.
Cases	28	9	120	65
Deaths	—	9	9	—
				17

The number of cases of enteric fever and diphtheria

notified from the various municipalities for the fortnight ended November 24, 1914, were as follows:—

Municipality.	Enteric Fever.	Diphtheria.
Bendigo	—	13
Prahran	—	9
Marong	—	7
Eaglehawk	4	—

INFECTIVE DISEASES IN QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, during the week ended November 21, 1914:—

Notifiable Disease.	Cases.
Enteric Fever	31
Diphtheria	35
Varicella	12
Phthisis	3
Infantile Paralysis	3
Total	84

INFECTIVE DISEASES IN WESTERN AUSTRALIA.

The notifications received by the Department of Public Health, Western Australia, for the week ended November 7, 1914, were:—

	Enteric Fever.	Diphtheria.	Phthisis.	Ery-sipelas.	Beri Beri.
Fremantle	—	—	2	—	—
Brownhill	1	—	—	—	—
Cottesloe	1	—	—	—	—
Subiaco	1	1	—	—	—
Leederville	1	—	1	—	—
Perth	2	—	1	—	—
Mt. Lawley	1	—	—	1	—
Bayswater	1	—	—	—	—
Midland Junction	1	—	—	—	—
South Perth	—	—	—	—	—
Broome	—	—	—	—	3
Kalgoorlie	3	—	—	—	—
Boulder	1	—	—	—	—
Coolgardie	—	1	—	—	—
West Subiaco	—	1	—	—	—
Bandee	1	—	—	—	—
Holyoake	1	—	—	—	—
Chidlow's Well	—	1	—	—	—
Fremantle South	1	—	—	—	—
Albany	—	—	1	—	—
Youanme	1	—	—	—	—
Collie	—	—	1	—	—
Kurrawang	1	—	—	—	—
Mullewa	1	—	—	—	—

The notifications received by the Department of Public Health, Western Australia, for the week ended November 14, 1914, were:—

	Enteric Fever.	Diphtheria.	Phthisis.	Ery-sipelas.
Fremantle	1	2	1	—
Fremantle East	—	—	1	—
Subiaco	—	1	—	—
Leederville	1	—	—	—
Perth	1	1	—	1
Mt. Lawley, N. Perth	1	2	—	—
Guildford West	—	1	—	—
Midland Junction	—	1	—	—
Kalgoorlie South	1	1	—	—
Collie	—	4	—	—
Nanga Brook	—	1	—	—
Bunbury	—	—	1	—
Cowcowing	1	—	—	—
Bridgetown	—	2	—	—
West Subiaco	—	1	—	—
Trafalgar	—	—	—	1
Leonora	1	—	—	—
Merredin	1	—	—	—

HEALTH OF THE METROPOLIS OF SYDNEY.

The mortality returns for the month of October, 1914, as supplied by the Government Statistician of New South Wales, shows that 556 deaths occurred in the Metropolis

of Sydney, including 26 deaths of individuals previously resident outside the metropolis, and deaths classified as taking place in the islands and shipping in the harbour.

Thus, calculating on an estimated population of 725,400, the death-rate for the month is equivalent to an annual death-rate of 9.36 per 1000 of the population.

Deducting the deaths of persons non-resident of the metropolis, in the Mental Hospitals of Leichhardt and Hunter's Hill (Callan Park and Gladesville), and adding the deaths of persons resident of the metropolis occurring at the Benevolent Asylums, Mental Hospitals and Consumptive Sanatoria, situated outside the metropolis, the number of deaths was 599, giving a corrected death-rate of 9.9 per 1000.

Among children under one year of age, 73 deaths were recorded for the metropolis.

There were 1731 births during the month, giving a rate of 28.63 per 1000 of the population, which is satisfactory, although slightly lower than the average of the previous five years.

The infantile mortality rate was 42 per 1000 births. The drop in the rate is noteworthy and most gratifying, being the lowest rate during the year, and 31 per cent. below the average for October of the previous five years.

Notifiable infective diseases were responsible for 7 deaths, of which one was due to diphtheria and 3 each to scarlet fever and enteric fever. Diarrhoeal diseases were credited with 13 deaths. Phthisis caused 43 deaths, pneumonia 38, cancer 49, diseases of the heart 57, Bright's disease 44, accident 24.

Compared with the average in October for the previous five years, there were increases in the number of deaths from Bright's disease and pulmonary diseases, and decreases in infective diseases, diarrhoea and enteritis.

One hundred and seventy-eight cases of scarlet fever, 101 of diphtheria, 29 of enteric fever, and 1 of infantile paralysis were notified during the month of October.

These figures show an increase on those of the previous month of 3 in the case of scarlet fever, and 8 in the case of enteric fever, and a decrease of 4 in the case of diphtheria.

Eighteen cases of phthisis (consumption of the lungs and consumption of the throat) were notified under the City Council's By-laws, and 13 premises were disinfected by the Council's trained staff after the deaths or removals of the patients.

(Signed) F. M. SUCKLING,
Acting Medical Officer of Health.

Special Correspondence.

(From Our Special Correspondent.)

CANADA LETTER.

The Profession and the War.

In 1899 Canada had no army medical service. The medical personnel of the militia now includes over seven hundred officers and eighteen hundred non-commissioned officers and men. The present war has welded together more closely than ever the different parts of the Empire, and the profession in Canada has responded most nobly to the call for assistance. The first Canadian contingent of over twenty thousand men has left for England, and with it has gone a medical corps of one hundred and twenty officers and seven hundred non-commissioned officers and men. The offers for service from both doctors and nurses have far outnumbered those that could be accepted, and such offers continue to come from every part of the Dominion. Each contingent will carry complete equipment for its base hospitals and field ambulances. No. 1 General Hospital, which accompanies the first expeditionary force, has accommodation for over five hundred patients, and a staff of twenty-one doctors and forty-two nurses. It will be in charge of Dr. Murry MacLaren, of St. John, New Brunswick, president of the Canadian Medical Association. Dr. F. G. Finley, of Montreal, will be in command of the medical, and Dr. Kenneth Cameron, also of Montreal, of the surgical department. No. 1 Stationary Hospital will probably be in charge of Major Lorne Drum. The staffs of both these hospitals have been recruited largely from Montreal

and from the Eastern part of Canada, and it is expected that the staffs of the hospitals which will accompany the next expeditionary force will be recruited from Toronto and the West.

At Valcartier, near Quebec, where the contingent that is now on its way to England was mobilized, the health of the troops has been excellent. No cases of typhoid originated at the camp, and pneumonia was rare. It was necessary to chlorinate the water, as it was found to be unfit for drinking purposes, and inoculation against typhoid was carried out systematically, although it was not compulsory; few objections, however, were made by the men, and there was no undue proportion of severe reactions. The vaccine used was prepared in the laboratories of the Ontario Board of Health. The site of Valcartier is a well-drained, sandy plain. The water is supplied by means of hydrants, which are placed fifty yards apart. The sanitary service is in charge of Dr. C. A. Hodgetts, medical adviser to the Commission of Conservation, Ottawa, and Dr. George Nasmith, of Toronto.

The women of Canada are assisting the Red Cross Society in the preparation of warm clothing and medical supplies. They have also done splendid work in assisting in the collection of money for the Patriotic Fund. This money will be used to assist the families of those who have volunteered. Almost five million dollars has been subscribed already. At present, Montreal leads with approximately \$2,000,000; Toronto comes next with \$983,500; Winnipeg, \$562,000; Ottawa with \$371,215, and so on. A Belgian Relief Fund has also been opened, and, up to date of writing, the subscriptions amount to \$101,794.50.

A hospital ship was offered to the British Government by the Canadian women, and for this purpose \$285,960 was collected. It was considered, however, that such a ship was not needed at present, and the money has been transmitted to the Admiralty. It is possible that a portion of it may be applied to the Queen's Canadian Military Hospital which has been established in London by the Canadian War Contingent Association. It is announced that the sum of \$100,000, which was offered by the Canadian Government for the organization and maintenance of Red Cross hospitals in France, has been accepted by the Minister of War. The Canadian Red Cross work in England and at the front will be under the direction of Colonel Jeffrey Hale Burland, who recently left Montreal to undertake his new duties. Colonel Burland has been closely identified both with anti-tuberculosis and Red Cross work in Canada.

The financial stringency is being felt very keenly by the hospitals, and many of them have been obliged to close some of the wards. Eleven members of the staff of the Montreal General Hospital have left for the front, and it is expected that Dr. Birkett, dean of the Medical Faculty of McGill University, will follow very shortly. The Graduates' Society of McGill University has undertaken to issue statements from time to time concerning the present war and its causes, with the object of encouraging graduates to give every assistance that they can—by themselves volunteering, by financial help, or by public speaking. The Graduates' Society is also prepared to raise funds to assist the McGill Regiment, which is being recruited from students of the University. Already over three hundred students are in training. It is intended that the men, when trained, shall join other formations, as they are needed; it is not expected that it will be possible to send a McGill Battalion to the front.

The medical profession, as a body, has expressed itself as willing to give its services free of charge to needy dependants of those who are serving with the Allied armies. Steps will be taken also to protect the interests and look after the private practices of medical men who are on active service. The Toronto Academy of Medicine was the first organization to pass such a resolution, voting at the same time \$1000 towards the Patriotic Fund. An equal sum has been voted by the Quebec College of Physicians and Surgeons, and it has been decided that medical students going to the war shall be given every consideration in the way of time allowance and fees. Similar action has been taken by some of the universities, and in the case of a medical student serving in hospital at the front, the experience thus gained will be credited to him.

Opening of the Session at McGill University.

Much regret was felt last spring when it became known that Dr. Shepherd intended to retire from the Deanship of the Faculty of Medicine, a position which he had held since 1908. A year previously Dr. Shepherd had given up the Chair of Anatomy, which he had occupied since 1883. The new Dean of the Medical Faculty is Dr. H. S. Birkett, a distinguished laryngologist, to whom many honours have come, and who is extremely popular alike with students and members of the profession. Dr. Birkett is Professor of Laryngology and Otology in the Royal Victoria Hospital; he was Vice-President of the Section of Laryngology and Otology of the British Medical Association, and, in 1908, President of the American Laryngological Association. He is a lieutenant-colonel of the Canadian militia, and, it is announced, intends shortly to leave for the front. The annual sessional lecture in medicine was given on Monday, October 5th, by Dr. Thomas Lewis, a noted heart specialist from London, the subject being "Syncope of Cardiac Origin."

The resignation of Dr. F. P. Walton, Dean of the Faculty of Law, occasioned great regret. Rather more than a year ago Dr. Walton went to Egypt to deliver a course of lectures at the Government Law School, Cairo. It was then expected that he would return in a year's time; however, he accepted an important position as legal adviser to the Government of Egypt, and, consequently, was obliged to sever his connexion with McGill. Dr. Walton is succeeded by Mr. Robert Warden Lee, who has been professor of Roman-Dutch law at University College since 1906. Mr. Lee comes to McGill with an enviable reputation, and should prove a worthy successor to Dr. Walton.

Medical Association Meetings.

The forty-seventh annual meeting of the Canadian Medical Association was held in St. John, New Brunswick, July 7th to 10th last. The meeting was a most successful one, and was attended by 287 members. The presidential address, delivered by Dr. Murray MacLaren, was greatly appreciated by all who heard it. Dr. MacLaren referred to former meetings of the Association which had been held at St. John in 1873 and in 1894, and by mentioning the visits to the shores of Nova Scotia of such explorers as De Monts, Champlain, and La Tour, gave to the address an historical setting. The latter part of the address dealt with the organization of the Association. The address in medicine was given by Dr. Thomas McCrae, of the Jefferson Medical College, Philadelphia, the subject being "The Method of Zsigmondy in the Practice of Medicine." Mr. J. Rutherford Morison, of the University of Durham, delivered the address in surgery, and Dr. Jellett, of the Rotunda Hospital, Dublin, gave the address in obstetrics. A public lecture on "Health Problems in Canada" was given by Dr. C. A. Hodgetts, of the Commission of Conservation, Ottawa. The discussion on "Intestinal Stasis" was of more than usual interest. From the radiologist's point of view, the evidence led to the conclusion that surgical interference was justifiable only when the presence of distinct organic disease was proved. An important amendment to the by-law of the Association was made. The Constitution provided that affiliated provincial associations should not hold an annual meeting if the Canadian Medical Association met in the province in question. This rule has proved a particularly arduous one in the case of Ontario, as, during the past few years the meetings of the national association have been held more frequently in that province than in any other. The by-law was amended to permit provincial associations to hold meetings irrespective of the meeting-place of the Canadian Medical Association. The annual meeting will be held next year in Vancouver, under the presidency of Dr. R. E. McKechnie.

The Ontario Medical Association held its thirty-fourth annual meeting in Toronto on May 26th to 28th last, under the presidency of Dr. C. F. McGillivray, of Whitby. Dr. Whitby's address dealt chiefly with the relations of the Ontario Association with the Canadian Medical Association—with the matter of affiliation and the difficulty mentioned above. The President was strongly in favour of closer union between the various medical associations of the Dominion. After some discussion, the questions of affiliation and the Workmen's Compensation Act in its relation to the medical

profession were referred to committees. The presidential address was followed by a symposium on syphilis. Dr. B. P. Watson delivered the address in obstetrics, and Dr. Finney, of John Hopkins University, gave the address in surgery. The remainder of the time was devoted largely to clinical meetings.

The second annual meeting of the Sanitary Inspectors' Association of Western Canada took place at Winnipeg on July 15th to 17th. The purpose of the Association is to improve sanitation throughout the province, and to raise the status of the sanitary inspector. Every encouragement is being given to such inspectors to take the examinations of the Royal Sanitary Institute of London. A branch of the Institute has already been established at Winnipeg, and it is probable that one will be opened at Calgary before long.

At the eighth annual meeting of the Saskatchewan Medical Association, which took place at Saskatoon on August 18th, 19th and 20th, the question of public health was discussed at some length, and it was recommended that the province should be divided into health districts, and that the medical health officers should be trained for that particular branch of work, and should devote all their time to it. Such an arrangement is in force in Ontario, and, to some extent, in the province of Quebec.

The fourteenth annual convention of the Canadian Association for the Prevention of Tuberculosis took place at Halifax on July 13th and 14th last. The secretary reported good progress during the year, no less than nine new institutions having been opened, in addition to the educational work which have been accomplished.

It was the intention that the annual meeting of the Canadian Public Health Association should be held this year at Port Arthur and its twin city Fort William, in the province of Ontario, from September 10th to 13th. Owing, however, to the unsettled conditions contingent upon the European war, it was decided to cancel the meeting.

Supply of Vaccine.

It has been very difficult to obtain reliable vaccines and serums, and, in some parts of Canada, these have been extremely costly. In the large cities it has been possible for the poorer members of the community to obtain treatment free of charge, but in cases of diphtheria for instance, the middle classes have often been unable to afford the necessary anti-toxin. In order to remedy this, the provincial boards of health are commencing to supply serums and vaccines, if necessary, free of charge, or at any rate at a very reasonable price, to any practitioner in the province.

The Melbourne Hospital and the Children's Hospital, Melbourne, are the losers by the de-licensing of the Australia Felix Hotel, in Lonsdale Street. This property was owned by a Mr. Richard Bowen, who provided by his will that his widow should receive a certain annuity during her lifetime, and at her death the whole of the rents and profits were to be paid in equal parts to the two hospitals. The widow died in 1905, and in 1913 the hotel was de-licensed. The Licenses Reduction Board ordered that the sum of £890 should be paid as compensation. On November 27, 1914, it was decided by Mr. Justice Hodges that the property should be sold immediately, and the proceeds of the sale divided between the two hospitals. It is estimated that the value of the de-licensed house is £825.

Medical Appointments.

Dr. William John Beveridge has been appointed Acting District Medical Officer and Public Vaccinator at Collie, Western Australia, during the absence of Dr. W. H. Rigby.

Dr. Smyth Yule has been appointed Medical Officer of Health at Queen's Park, Western Australia, Dr. H. Teague having resigned.

Dr. F. M. Suckling has been appointed Acting Medical Officer of Health for the Metropolitan Combined Sanitary Districts of Sydney during the absence of Dr. J. S. Purdy.

Dr. F. E. Hutchinson has been appointed Medical Officer of Health for the Stylesford Borough, Victoria, in place of Dr. H. G. Loughran, resigned.

Dr. L. C. Lade has been appointed Acting Public Vaccinator for the S.W. District at Learmouth, Victoria, during the absence on military service of Dr. Courtney.

Medical Appointments Sought, etc.

LOCUM TENENS.—Fellow of the Royal College of Surgeons of England desires position as locum tenens early in December. Apply by letter to No. 645 "Medical Journal of Australia," Melbourne or Sydney.

TO LET.—Professional Suite, first floor Saunders Chambers, 245 Elizabeth Street, overlooking Hyde Park. Five large rooms and offices with modern conveniences, electric light and elevator; if required could be sub-divided. For further particulars apply Caretaker on premises or to A. Saunders, 805 George Street Sydney.

FOR SALE.—15 h.p. Cottin Desgouttes, 5-seated body, with all latest improvements, car in perfect order, one year old; has done only 3000 miles. Price, £400. Owner leaving for seat of war. Apply Dr. Read, Tel. 486, Wahroonga.

FOR SALE OR TO LET.—Neutral Bay, Doctor's VILLA, recently occupied by a medical man for six years; splendid opening for doctor starting practice. Terms, apply Mr. EDWARDS, 48 McLaren Street, North Sydney.

Proceedings of Australian Medical Boards.

TASMANIA.

The following person has been registered under the provisions of the "Medical Act, 1908," as a duly qualified medical practitioner:—

Henry Charles Graham, M.B., B.S. (Melb.), 1913.

Births, Marriages, and Deaths.

The charge for inserting announcements of Births, Marriages and Deaths is 5s., which sum should be forwarded in money orders or stamps, with the notice, not later than the first post on Tuesday morning, in order to ensure insertion in the current issue.

Birth.

BRANDON.—On November 22, 1914, at 265 Elizabeth St., Sydney, the wife of Dr. Spiller Brandon—a son.

Marriage.

BROWN-SIMPSON.—On November 13, 1914, at All Souls' Church, St. Peters, Adelaide, by the Rev. W. G. M. Murphy, Rector and Rural Dean, Gilbert Brown, M.B., Ch.B., of Snowtown, to Marie Simpson, M.B., B.S., D.P.H., of Nottingham, England.

Books Received.

A MANUAL OF PHYSIOLOGY, WITH PRACTICAL EXERCISES, by G. N. Stewart, M.A., D.Sc., D.H.P., 1914. London: Baillière, Tindall & Cox; Seventh Edition, University Series, Demy 8vo., pp. 1132. Price 18s. net.

PRACTICAL PAEDIATRICS, Vols. 1-11, by Mackee and Wells, 1914. Philadelphia: P. Blakiston's Son & Co.; Melbourne: Stirling & Co.; Royal 8vo., Vol. 1, pp. 546; Vol. 11, pp. 1182.

BRITISH PHARMACOPOEIA (published under the direction of the General Council of Medical Education and Registration of the United Kingdom), 1914. London: Constable & Co., Ltd.; Demy 8vo., pp. 602.

MENTALLY DEFECTIVE CHILDREN, by Alfred Binet and Th. Simon, M.D. (authorized translation by W. B. Drummond, M.B., C.M., F.R.C.P., Edin.), with an appendix containing the Binet-Simon tests of intelligence by Margaret Drummond, M.A., and an introduction by Professor Alexander Darrach, 1914. London: Edward Arnold, Crown 8vo., pp. 180. Price 2s. 6d. net.

LEAD POISONING, FROM THE INDUSTRIAL, MEDICAL AND SOCIAL POINTS OF VIEW, by Sir Thomas Oliver, M.A., M.D., F.R.C.P., 1914. London: H. K. Lewis; Crown 8vo., pp. 204. Price 5s. net.

THE INFANT—NUTRITION AND MANAGEMENT, by Eric Pritchard, M.A., M.D. (Oxon.), M.R.C.P. (Lond.), 1914. London: Edward Arnold; Crown 8vo., pp. 265. Price 3s. 6d. net.

PASTEUR AND AFTER PASTEUR, by Stephen Paget, F.R.C.S. (Medical History Manuals), 1914. Adam and Charles Black; Illustrated, Crown 8vo., pp. 152. Price 3s. 6d. net.

ROSE AND CARLESS'S MANUAL OF SURGERY FOR STUDENTS AND PRACTITIONERS, revised by Albert Carless, M.B., M.S. (Lond.), F.R.C.S.; Ninth Edition, University Series, 1914. London: Baillière, Tindall & Cox; Illustrated, Demy 8vo., pp. 1408. Price 21s. net.

Diary for the Month.

- Dec. 8.—New South Wales Branch, B.M.A., Council Meeting.
 Dec. 11.—New South Wales Branch B.M.A., Ordinary Meeting.
 Dec. 11.—Queensland Branch, B.M.A., Annual Meeting.
 Dec. 15.—New South Wales Branch B.M.A., Council Meeting.
 Dec. 16.—Western Australian Branch B.M.A., Branch Meeting.
 Dec. 22.—New South Wales Branch B.M.A., Committee Meeting.

Important Notice.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.

APPOINTMENTS.

QUEENSLAND.
 (Hon. Sec. B.M.A. Building, Adelaide Street, Brisbane).

Brisbane United F.S. Institute.
 F.S. Lodges at Longreach.
 F.S. Lodges at Warwick.

WESTERN AUSTRALIA.
 (Hon. Sec. 230 St. George's Terrace, Perth).

Swan District Medical Officer.
 All Contract Practice Appointments in W.A.

Australian Natives Association.
 Balmain United F.S. Dispensary.
 Burwood District F.S. Institute.
 Carrington Lodge No. 75, P.A.F.S. of A., Randwick.
 Goulburn F.S. Association.
 Leichhardt and Petersham Dispensary.
 M.U. Oddfellows Med. Inst., Elizabeth Street, Sydney.
 N.S.W. Ambulance Association and Transport Brigade.
 N. Sydney United F.S.
 People's Prudential Benefit Society.
 Phoenix Mutual Provident Society.
 F.S. Lodges at Braidwood.
 F.S. Lodges at Casino.
 F.S. Lodges at Lithgow.
 F.S. Lodges at Mudgee.
 F.S. Lodges at Orange.
 F.S. Lodges at Parramatta, Granville, Penrith and Auburn.
 Killingworth Colliery, Newcastle.
 Seaham Colliery No. 1, Newcastle.
 Seaham Colliery No. 2, Newcastle.
 West Wallsend Colliery, Wallsend.

NEW SOUTH WALES.
 (Hon. Sec. 30-34 Elizabeth Street, Sydney).

SOUTH AUSTRALIA.
 (Hon. Sec. 3 North Terrace, Adelaide).

The F.S. Medical Assoc. Incorp., Adelaide.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to the "Medical Journal of Australia" alone, unless the contrary be stated.

All communications should be addressed to "The Editor," "Medical Journal of Australia," B.M.A. Building, 30-34 Elizabeth Street, Sydney, New South Wales.